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# ON THE TEMPERATURE IN CASES OF APOPLEXY, AND ON THE OCCURRENCE (1) OF ŒDEMA AND (2) OF LOSS OF THE KNEE-JERK IN THE PARALYSED LIMBS IN HEMIPLEGIA.

BY

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The following cases illustrate some of the more interesting points with regard to the temperature of the body in vascular lesions of the cerebral hemispheres. Briefly stated, the chief facts known are—that in cases of cerebral hemorrhage there is an initial fall of the body-temperature; that in rapidly fatal cases this subnormal temperature is maintained, but in others which live for some hours it may be succeeded by a rise to a high level; that in cases which prove fatal after a few days the initial fall is followed by a stationary period of return to the normal or near it, ending in a rise of the temperature before death; and in cases which recover, the temperature after an initial fall and rise returns to normal, or, rather, remains somewhat subnormal for some time. In softening due to thrombosis,

there is no initial fall, or it is very slight; the temperature rises, and this is followed by secondary oscillations of considerable amplitude.

Dr. Dana called attention to the fact that in cases of cerebral hemorrhage, accompanied with hemiplegia, the temperature upon the paralysed is higher than that upon the sound side, and that in acute cerebral softening from thrombosis or embolism this difference in temperature is not present. He says: "There are exceptions to this rule which I have laid down, but these exceptions are rare, and are to be explained either on the ground that the hæmorrhage is very small or the acute softening is very extensive." [1]

This difference of temperature on the two sides in hemorrhage may be of practical use in the diagnosis from softening due to thrombosis or embolism. Dr. Dana further says that he has never found any perceptible temperature-disturbance in hemiplegia due to embolism, no matter how severe and pronounced the central disturbance was.

Case 1.—The first case that I wish to report in illustration of the temperature changes in cerebral hemorrhage is that of a man, aged 48, who had had two attacks of rheumatic fever. There was a history of loss of power in the left side and muffled speech on December 9th, 1898, since which day patient had been confined to bed. On admission, December 17th, patient had left hemiplegia, and was in a dazed, heavy mental state. Early on December 19th he passed into a condition of profound coma, in which he died. The urine contained a considerable quantity of albumin.

The necropsy showed that there was subacute interstitial nephritis, the heart was much dilated, and both ventricular walls were hypertrophied and showed patches of fibroid degeneration. The right cerebral hemisphere was enlarged—the convolutions flattened—and so soft that it was removed with difficulty. The white and grey matter of all the parts of the hemisphere corresponding to the distribution of the middle cerebral artery, with the exception of a narrow zone on the ventral aspects of the optic thalamus and nucleus lenticularis, were yellow, softened, and broken down. A clot was found obstructing this artery, and its branches were thrombosed. A large recent hemorrhage had ploughed up the white substance of the frontal lobe and extended to the surface, about the middle part of the second frontal convolution. The other parts of the brain were normal.

The chart indicates the very high rise of temperature which accompanies the fatal termination in a large cerebral hemorrhage, the temperature on the paralysed side being regularly

[1] *Post-Graduate*, 1896, xi. 316.

a degree higher than that on the sound side, and the interesting fact that thirty minutes after death the temperature on both sides was 106°—that is to say, the temperature on the paralysed side ceased to rise after death, whilst that on the sound side rose one degree. Does this indicate that the healthy side of the brain exerts to some extent an inhibiting influence on the rise of temperature on the opposite side of the body, this inhibition ceasing, of course, with death?

Case 2 was that of a woman, aged 44, a heavy drinker, who was admitted with right hemiplegia and partial right hemianæsthesia. She was in a very dull, stuporous mental condition. She had had an apoplectic seizure five days before admission.

At the necropsy a large hemorrhage was found to have taken place into the left optic thalamus, and this had later ruptured into the left lateral ventricle, which was filled with bloodclot.

The chart shows the temperature disturbances due to the initial hemorrhage into the thalamus, the temperature on the paralysed varying from half to two degrees higher than that on the sound side; and this difference between the two sides was maintained in the rise of temperature which immediately preceded death, which was due to the effused blood bursting into the lateral ventricle.

Case 3.—A patient admitted (aged 57) with left hemiplegia and hemianæsthesia, which had come on during the night seven days before admission. He was sensible on admission, but gradually became more dull, and could give no account of himself. After a short period of quiet delirium he gradually became deeply comatose, and so died. Pupils small and contracted. A marked feature in the case was the paralysis of the muscles of the left side of the abdomen, which caused the abdominal wall to be flaccid and bulged out.

*P.M.E.*—The white matter of the right hemisphere was extensively softened and diffluent (white softening). This was most marked in and around the internal capsule, lenticular nucleus, and optic thalamus, extending a little way into the posterior part of the hemisphere and for a considerable distance into the frontal lobe.

The chart shows a rise of temperature before death, with a fall at death; the temperature of the paralysed side was two degrees above that of the sound side on admission, and for the most part slightly above the latter until just before death, when the temperature on each side fell together to the same level. In this extensive softening the temperature difference between the two sides rather resembled that of hemorrhage, but was more irregular.

Case 4.—A man, aged 46. The symptoms of his illness began with tingling in the left hand and arm, and twitchings of the muscles of this arm and the left leg for a few days. Six days before admission he had a fit, in which he became unconscious, and in which there were twitchings of the muscles of the whole of the left side of the body. This fit was followed by left hemiplegia. After admission he had two or three fits of the same kind, and twitchings of the left arm and calf-muscles were frequently observed. He was dull and drowsy on admission, but subsequently slightly improved; he had very little power of movement of either left arm or leg. Drowsiness was markedly increased on the twelfth day of the illness, and on the fourteenth day deepened into coma, in which he died on the eighteenth day.

A large area of softening was found in the region of the right lenticular nucleus and optic thalamus.

The chart shows that the temperature is irregular, and that on the paralysed and sound side fairly correspond with each other.

Case 10.—Hemorrhage into the pons Varolii. The chief symptoms were fits, consisting of twitching of the muscles on both sides of the body, with stertor, frothing at the mouth, and cyanosis. Apart from the fits, in the intervals between them convulsive twitchings of the muscles occurred. All four limbs were paralysed, and the motions and urine passed unconsciously. There was drowsiness at first, which passed into coma. There was no oculo-motor paralysis, and the pupils on admission were equal and not contracted. On the last day of life there were irregular, horizontal, oscillating movements of the eyeballs, and alternating contraction and dilatation of the pupils, which were, however, never strongly contracted. The face was slightly drawn to the right; the abdomen was retracted. The superficial reflexes were normal on admission, and there was double ankle-clonus.

*Post mortem* the kidneys were contracted and granular. Two hemorrhages were found in the pons—one on the left side, about $\frac{1}{2}$ inch in long (transverse) diameter, just above upper end of fourth ventricle, in the tegmental region, dorsal to the fillet; the other, about $\frac{1}{8}$ inch in diameter, a little lower down, close to the raphe, at the same level in the pons as the first hemorrhage and on the right side.

The temperature was persistently subnormal and identical on both sides of the body. It is interesting to note the subnormal temperature in the presence of frequent convulsions.

As to the mode of production of a high temperature under such conditions, one must premise that it is not due to muscular convulsions, for these are often absent. Although the subject is an obscure and difficult one, it is hardly to be doubted that the thermo-taxic mechanism is the one at fault. The arguments for the location of the thermo-taxic mechanism in the central nervous system need not be recapitulated; they are well known. This localisation has been further established by numerous

experiments to be probably in or near the corpus striatum. Thus Hale White,[1] experimenting on rabbits, found that "lesions of the corpus striatum, if not large enough to cause shock and hemorrhage, lead to a considerable rise of temperature, on the average equal on the two sides of the body, even if only one corpus striatum is damaged." Although lesions of the septum lucidum and posterior part of the upper surface of the cortex in rabbits also caused a rise of temperature, his experiments showed that injuries to the corpus striatum were by far the most important.

The normal regulation of heat is effected by variations in the loss of heat—for a greater amount of heat is produced than is actually necessary—"the heat-producing activities of the organism tend to exceed . . . . its requirements."[2] The heat-regulating mechanism being disordered in cerebral lesions, the temperature tends to rise. The observation that although the temperature rises on both sides of the body, it remains lower on the side of the lesion, is difficult to explain; possibly the sound hemisphere, although much disordered, may still exert some controlling influence on the temperature of the opposite side of the body. In this connection the fact that in the first case the temperature on the sound side rose one degree —to the level of that on the paralysed side—after death is interesting.

In the remaining cases recovery took place, and therefore the diagnosis was not confirmed by *post-mortem* examination; but the cases were selected as being ones in which the diagnosis from clinical symptoms appeared reasonably certain. The first, No. 5, illustrates again the difference between the temperature on the two sides in hemorrhage; No. 7, a similar, but slighter, difference in a case of cerebral syphilis, probably from occlusion of a vessel; No. 8, the subnormal temperature which may persist some weeks in hemiplegia; and No. 9, a want of correspondence between the temperature in the axilla and the surface temperature.

[1] *Brit. M. J.*, 1891, i. 150.

[2] Burdon-Sanderson, "The Doctrine of Fever"; Clifford Allbutt's *System of Medicine*, 1896, vol. i., p. 150.

Case 5.—In this case, although there was no autopsy, the lesion was almost certainly a hemorrhage into the right cerebral hemisphere. The chart shows the difference of temperature on the two sides (paralysed highest) seven days after the apoplectic stroke; after another week the temperature became normal on both sides. Another point of interest was the marked diminution of the knee-jerk in the paralysed leg; it could only be obtained with great difficulty. At the same time rigidity came on in the usual way, and was quite marked one month after the fit. The leg became very tender on movement, and the left knee-joint was swollen and tender.

Case 7.—From a case of hemiplegia due to syphilitic occlusion of a branch of the right middle cerebral artery. The chart shows a difference between the two sides of at first one to two degrees, the temperature on the sound side being markedly subnormal; then follow, as recovery proceeds, a number of rather wide oscillations lasting for about a week, subsequently the temperature on both sides returned to normal.

Case 8.—This chart is taken from a case of hemiplegia seven weeks after the onset. The subnormal temperature on both sides of the body is noticeable at so long a period after the initial lesion; as the patient only came under observation some time after the seizure and recovered, the exact nature of it could not be ascertained. It was probably a hemorrhage. There was no albuminuria.

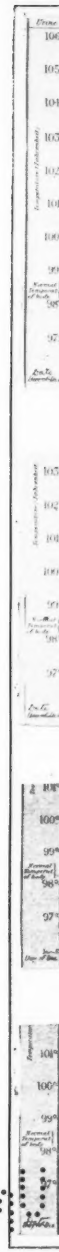
In some cases of hemiplegia which are associated with disease of the kidneys, a persistent low temperature may be noted, but there was no such reason for it in this case.

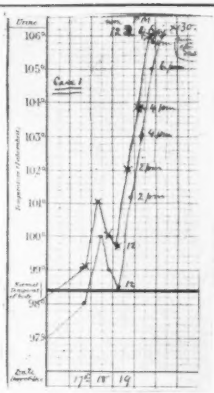
Case 9 was one of hemiplegia probably due to softening from thrombosis in the course of chronic Bright's disease. The chart shows that the difference in temperature between the two sides is slight and inconstant. On the 5th August, when the temperature in the axilla was half a degree higher on the paralysed than on the sound side, the surface-temperature was nearly $1\frac{1}{2}$ degrees lower on the former than on the latter. This case presented another symptom sometimes met with in hemiplegia—excessive tenderness to touch or movement of the paralysed limbs. The patient screamed loudly if they were moved or touched. This was not attributable to rigidity of the limbs, as the rigidity was only slight. Another symptom she suffered from was well-marked œdema of the paralysed side of the body only, especially of the arm and leg. Associated with this appeared trophic disturbances in the shape of a sore on the heel and a blister if the skin was thrown into a crease or fold anywhere by her position in bed.

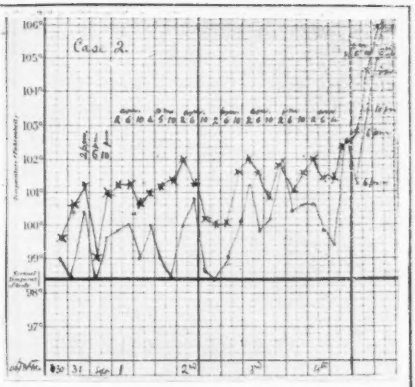
The presence of this unilateral œdema is, I think, to be attributed to a change in the innervation or nutrition of the vessel-walls, and may be compared to the experimental œdema in the leg produced after division of one sciatic nerve in the leg after the production of artificial hydræmia.

When albuminuria is present the above seems to be the most reasonable explanation of œdema of the paralysed side, and is in accordance with known factors in the production of œdema. But in other cases the etiology is not to be thus

In each chart the starred line indicates the temperature on the paralysed side. Except in cases 1 and 2, in which the temperature is shown at short intervals, the charts indicate the morning and evening temperatures.




Case 1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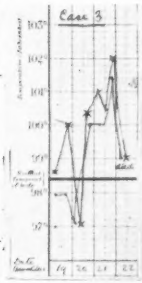
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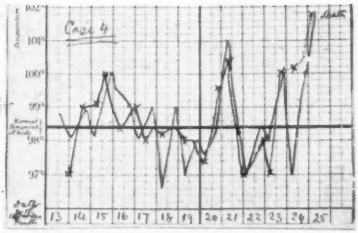
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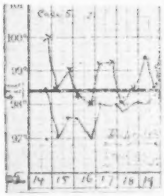
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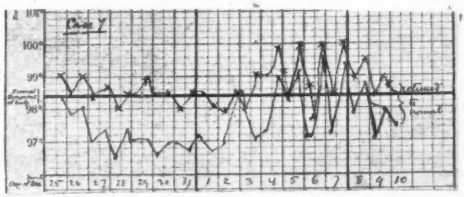
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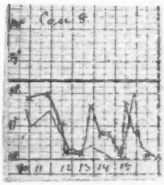
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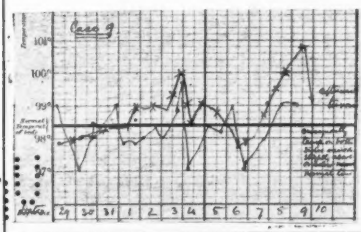
Case 9

Case 10

explained, for a similar œdema may occur in hemiplegia in cases in which albuminuria is absent, and there is no reason to suspect disease of the kidneys. Thus in a woman who suffered from mitral disease, and in whom left hemiplegia was presumably due to thrombosis followed by softening, but who had no albuminuria nor other evidence of kidney-disease, five weeks after the attack œdema of the paralysed arm and hand came on, and the limb became painful to the touch, and there was at the same time marked rigidity. Indications of vaso-motor disturbance were found in cold sweats and lividity confined to the hand and forearm, and this limb was always colder than the right. The leg was less affected, and began to recover power early. There was, of course, no evidence of local pressure upon or of disease of the vessels of the left arm.

In both these cases the appearance of œdema was accompanied by pain, which was more or less constant, but much increased by movement. This pain was not the same as that which is aroused by forcibly moving the parts of a rigidly-contracted limb, and was apparently not connected with the rigidity present. The appearance of this painful œdema is an unfavourable sign in the prognosis as to recovery of power in the limbs, and is difficult to relieve by treatment. The first of the above two cases (case No. 9) exhibited also another phenomenon which I have observed in three cases of hemiplegia—a marked diminution or sometimes loss of the knee-jerk in the paralysed leg, the exact contrary of what usually obtains. I append brief notices of the two other cases.

A man, aged 71, was admitted three days after onset of a seizure, probably due to thrombosis, which occurred in the night, and was accompanied by twitchings of the right side of the face, right arm and leg, but not by complete loss of consciousness. Right hemiplegia resulted, and was at first accompanied by anæsthesia of the whole of the right lower extremity, which was soon reduced to a patch of anæsthesia in the area of distribution of the N. cutaneus femoris. There was slight concentric contraction of the right visual field and a moderate amount of albumin in the urine. He recovered power gradually, and was able to walk out of the Hospital four weeks later. The right knee-jerk was completely absent, and could never be obtained by any method or by reinforcement, whilst the left knee-jerk was active and the superficial reflexes normal. The leg became moderately stiff, but was never very rigid; it was not, however, flaccid. Subsequent examinations showed the right knee-jerk to be always absent.

In the case of a man, aged 65, with left hemiplegia, partial, not complete, hemianæsthesia, left hemianopsia, and with slight movements of athetosis in the left hand, the left knee-jerk was also absent. On the right side it was normal. The other reflexes were normal, and the amount of rigidity present in the paralysed limbs was only moderate.

I cannot give any explanation of the loss of the knee-jerk on the side of the hemiplegia; especial care was taken to ascertain that it was really absent. In two of the cases there was also some anæsthesia on the affected side; but in the other the sensory disturbance was in the opposite direction, consisting of increased pain and tenderness.

## FRACTURE OF THE PATELLA.

BY

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IN a case of fractured patella there is often some difficulty in knowing what treatment it is best to recommend to the patient and his friends, and there are many points to be considered. I do not mean to go into all details; these are best left to the judgment of the surgeon in charge of the case. I will briefly mention the five methods of treatment that are now in fashion, and offer some remarks on each.

Firstly, the plan without operation. This, the old one, consists of rest with the application of splint and bandages. There are various excellent ways of drawing the fragments together, and perhaps in almost the majority of cases this method is the one to be recommended, and it often gives fair results; but the best result that can be hoped for is a ligamentous union with more or less impairment of extension, and the probability is that the individual will never be able to run or climb a ladder.

Secondly, subcutaneous silk ligature, by surrounding the knee-cap either laterally or vertically by a stout silk cord. In

the latter case the ligature is passed by means of a strong needle right into the joint, and is left in, resting on the condyles. I have had no personal experience of this plan, but I cannot imagine that it would be successful in many cases when the tilting of the fragments and the indipping of the fibrous covering are considered. The tilting is present in most cases, as seen in Fig. 1, and is sometimes remarkable, as in one case which I wired, where the fractured surface of the upper fragment was directly forwards. The dipping in of the fibrous covering has been present and has given some trouble in all cases that I have seen operated on.

Thirdly, the recently recommended method of massage of the thigh muscles, and passive movement of the knee from the commencement of the case. This is advocated by those who think that the cause of bad results in cases that have not been operated on is to some extent atrophy of the quadriceps, and contraction of the fasciæ from want of use. I cannot say anything about this treatment from my own experience—I want to see it tried—but it can never result in bony union if the fragments have been separated, and a ligamentous union can never give the support that a bony one gives.

Fourthly, the method of an open operation and sewing up the fibrous covering and split lateral expansion of the quadriceps by buried sutures. This has, to my mind, little to recommend it in comparison with wiring, as the operation would be as severe, and the result not so secure.

Fifthly, wiring. It is usual to make a longitudinal incision and then carefully to scrape away all material between the fragments, to bore and pass the wire, then to irrigate the joint, washing out all clot, then tighten the wire. I always put a drainage tube into the joint on the outer side, and remove it in twenty-four hours. One can generally rely upon a single stout silver wire. A good plan, when the lower fragment is small, is to pass two wires through one hole in the lower, and separate them to pass through two holes in the upper. This gives a very firm hold. The method was suggested by my colleague, Mr. Paul Bush.

Wiring the patella should not be done too soon after the

accident, the joint should be allowed at least forty-eight hours to begin to recover from the immediate effect of the injury. I have seen a disastrous result from the operation being done on the same day as the fracture. Certainly the operation should not be undertaken by any one who has not complete confidence in his antiseptics and in his carpentering skill, nor in cases where the general health is not good; but as far as my experience and my ideas go, it is the right thing to recommend in young adults who have to use their legs in earning their living, or who wish to be able to indulge in a fair amount of active exercise.

I briefly mention two special cases:—

CASE 1.—F. A., aged 40. When playing hockey on November 27th, 1897, slipped and sustained a transverse fracture of the left patella.

November 30th. Patella wired with a single silver wire, joint washed out with boracic lotion and drained. Wound healed well.

Sixteen days later passive movements were begun. Patient went home January 7th, six weeks after the operation.

He played cricket all the following summer, and on September 10th, 1898, whilst bowling in a match the right knee-cap gave way. He was found to have a transverse fracture just below the middle.

September 19th. Right patella wired—one silver wire (*Vide* skiagram, Fig. 2.)

October 11th. Twenty-two days after operation passive movement was commenced—about fifteen degrees from horizontal.

Patient went out well six weeks from the operation, well able to bend both knees.

He is playing cricket this season.

CASE 2.—C. W. In December, 1892, fractured left patella. This was treated at the Bristol Royal Infirmary with back splints and cross-bars, the fragments being pulled together by strapping. He wore a leather splint for some months. Six months later he was readmitted for stretching of the union, and was treated as on the previous occasion.

March 2nd, 1899, was admitted for a similar accident to the same patella—the interval between the fragments was fully one inch. (*Vide* skiagram, Fig. 3.)

March 14th. I cut away the dense fibrous tissue between the fragments, and freshened the ends of the bones and brought them together with two wire sutures passed through one hole in the lower and two holes in the upper fragment. (*Vide* skiagram, Fig. 4.)

March 29th. Wounds were quite healed—passive movements were begun sixteen days after operation.

April 24th. Patient went out, able to walk easily without a splint, bending his knee fairly well with no separation of fragments.

Fig. 1.

Fig. 2.

Fig. 3.

Fig. 4.

# IDIOPATHIC THROMBOSIS OF THE PORTAL AND CONTRIBUTORY VEINS.

BY

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CASES of thrombosis of the portal vein, other than those caused by some septic influence, are of such rare occurrence that the subject is hardly to be found in text-books on medicine, and in the enormous mass of medical literature that now exists only some dozen cases comparable to the one to be related are to be found.

The history and course of the case which was recently under my care at the Children's Hospital is singularly complete, and consequently interesting, for the boy was under the observation either of my colleagues or myself for eight years. It is as well, perhaps, to admit at the beginning of this paper that the condition which was found *post mortem* was not diagnosed during life, but in this I do not find myself without good companions; for not only did my colleagues not recognise the true nature of the case, but in all those that I have collected from various medical publications the state of affairs was recognised but once, and that by Sir William Jenner. Whether the line of treatment adopted would have been modified had a correct diagnosis been made is another matter. This I shall refer to later.

Herbert R. was first admitted to the Hospital in October, 1891, at that time being under the care of Dr. Edgeworth, who has kindly supplied me with the notes he made at the time. The child was then 4 years and 9 months old, and had been ill for three months with increasing size of the abdomen. He was the fourth child of eight, three of whom were dead; and he is stated to have wasted from birth (a statement one often hears, but which is difficult of belief). There was no history of paternal syphilis. Examination revealed a small quantity of free fluid in the peritoneal cavity and an enlarged

[1] Read at the April Meeting of the Bristol Medico-Chirurgical Society.

spleen, whose lower edge was three inches below the costal margin. There appeared to be no disease in any other organ. There were no enlarged lymphatic glands, and no albumin in the urine. The bowels were open rather freely, the motions being a dirty yellow colour and acid in reaction. The red corpuscles were 70 per cent., the proportion of red to white 200 to 1, and the hæmoglobin 75 per cent., though a few days after the percentage was less. In December he was discharged; but in February, 1892, was re-admitted, with a history of having vomited up some blood. Examination showed that the spleen had not altered in size, but the liver was two inches below the costal margin. There was no ascites. As no hemorrhage occurred, he was sent home again in March.

In October, 1895, he was again admitted, his parents stating that he had passed some blood by the bowel. He was sick several times soon after admission, but it was not till November 9th that he brought up five ounces of pure, bright, alkaline blood, and a few hours later six more. This reduced the hæmoglobin to 20 per cent. On the 17th he brought up twenty-four ounces of blood and passed a black motion, and on the 18th, in another attack of hæmatemesis, he vomited eight ounces. This reduced him to an extreme state of anæmia, but he recovered so far that the hæmoglobin rose as high as 60 per cent., and the red corpuscles from 1,080,000 to 5,250,000, and he went on till January 13th, 1894, when he vomited twenty ounces of mixed blood and food. This was the last attack during this stay in the Hospital, and he improved so much that he went home in May. On leaving, his spleen was observed to have reached to within half an inch of the umbilicus.

In June, 1898, he came in again for a month; but keeping quite well all the time, though rather anæmic, he went home again. In November he again was admitted, after having, it was said, vomited "two quarts of blood." Whatever amount this really represents cannot be certain; but on the following day, the 9th, he brought up altogether thirty-three ounces, reducing him to such a collapsed condition that he was only brought back to life by transfusion with saline solution and inhalations of oxygen. (I may parenthetically remark that of the number of times I have employed oxygen, I believe this is the only case in which it did good, and here it was probably assisted greatly by the transfusion.) After this attack he slowly but gradually improved, and there was no evidence of hemorrhage till December 5th, when he passed black motions for two days. This hemorrhage, whenever it took place, did not seem to affect him, as his improvement continued till the 19th, when, after a very restless night, he vomited four pints and seven ounces of blood-stained fluid in the twenty-four hours. How much of this was blood cannot be said; but after the first symptom of hæmatemesis no fluid, except ice, was allowed, so that the actual quantity of blood must have been large. The next day, the 20th, he passed some bright blood—five ounces—by the bowel, and vomited thirteen ounces of pure blood. Till January 16th he was free, but on that day he began to bring up small quantities of blood, amounting in all to ten ounces. This was almost entirely clotted. He also brought up eight ounces of clear fluid, alkaline in reaction and containing a trace of albumin, the source of which I cannot explain. The following day, for the first time, his temperature rose, reaching 101°, and he passed some black fæcal matter. On the 22nd he again vomited, this time twelve ounces of bright red clotted blood. These repeated attacks of hæmatemesis reduced him to an extreme state of collapse, and, with repeated small vomits and passing of small black motions, he died on February 4th.

During all this time the physical conditions did not vary. A small amount of fluid was always present in the abdomen, which appeared to increase just before an attack of hæmatemesis came on. The spleen reached to within half an inch of the umbilicus, but the liver apparently recovered its normal size. A trace of albumin was observed at times in his urine, and his anæmic condition gave rise to hæmic murmurs.

One peculiar fact I noticed about the boy, and that was a curious earthy smell. I do not remember ever to have noticed this in any other patient, and on my calling attention to it others who happened to be with me also observed it.

The necropsy was made by me the following day. The body was very pale, and there was only slight rigor mortis. On opening the thorax a small quantity of fluid was found in each pleural cavity. The lungs were healthy; the heart was small, the right side flaccid and empty, the left full of clot; there was no pericardial fluid. No disease of the valves was present. The abdominal cavity contained several pints of clear fluid; the intestines were in a natural position, and there were no adhesions except those to be mentioned later round the spleen. The only abnormality noticed was the greatly enlarged spleen. The upper surface of this organ was firmly adherent to the diaphragm in one place, and the rest had a dull grey colour, and looked as if its surface was covered with lymph, in reality being due to the thickening of the capsule. On moving it, it was found to be also firmly adherent to the stomach, so that the two organs were removed together. Unfortunately, I did not then recognise the condition, and cut through the veins, which were thrombosed, and only removed a short portion of the duodenum. The liver, which was slightly smaller than one would have expected for a boy of this age, was pale, but otherwise normal; the gall-bladder was very large, and full of bile. The pancreas and mesentery were found to be much overgrown with fibrous tissue, and about two feet down the small intestine a deeply-congested patch, with hard knotted veins leading to it, was found and removed. The only other pathological matter of interest found was a horseshoe kidney, the second I have found while acting as pathologist to the Children's Hospital. On examining the spleen and stomach more closely, it was found that the splenic vein was full of hard discoloured clot, and that a new set of vessels had developed, which led into the spleen at various points. Tracing the vein forwards, the clot was found to extend to the vein in the small curvature of the stomach, the coronary, while, to compensate for this obstruction to the flow of blood, large veins, which were easily seen in the recent state, coursed across the stomach from the right gastro-epiploic vein. The coronary vein was blocked as far as the duodenum, but the venous communications there seem to have been sufficiently good to have prevented any engorgement. In the small intestine this did not hold good, and a branch of the superior mesenteric, which had become involved in the clot, produced a deeply-congested patch about four inches long. Here the walls of the intestine were much thickened, and the mucous membrane of a deep chocolate colour. Round the pancreas there was a considerable overgrowth of connective tissue, and the plexus of veins known as the pancreatico-duodenal and its branches were all filled with firm discoloured clot. The portal itself, as it entered the liver, was hard and cord-like, but on cutting into the liver substance it did not appear that the clot extended to any depth, nor did I find any compensatory branches. The inferior mesenteric vein was not affected.

From the cases I have found reported elsewhere, I conclude that the symptoms in this case were not unusual, but were, in fact, those seen in this condition. Hæmatemesis of more or less severe type—melæna, enlargement of the spleen, and ascites were present in every case. Osler[1] records a case in which there were hemorrhoids and no ascites, the spleen was much enlarged and adherent to the stomach and diaphragm; the liver small, and the veins of the spleen and the rectum were thrombosed. The portal vein was represented by a fibrous cord; there was no calcification of the walls, but some at the junction of the splenic and superior mesenteric. His opinion was that the primary thrombosis was portal and not splenic. In his *Principles and Practice of Medicine*, in 1892, p. 429, he says it is rarely seen except in cases of cirrhosis. These cases are rare no doubt, but from the cases I have found I should say cirrhosis was a rare cause of thrombosis, as its absence is remarked in every case except one. In Sir William Jenner's case,[2] though the patient was admittedly a heavy drinker, no cirrhosis was found. This case is a peculiar one, from the fact that the abdomen burst. This came about in the following manner: The patient was tapped for ascites, and the puncture ulcerated, and an ulcer in the intestine, caused by thrombosis of the mesenteric vein, perforated, allowing gas to escape into the peritoneal cavity, and so causing the explosion. In this case the spleen was large. Dr. Lyons[3] mentions the case of a woman aged 45, who was tapped to the extent of 500 quarts in eight months for ascites, in whom at the necropsy a clot was found in the portal vein. He particularly remarks on the absence of cirrhosis, and mentions that the liver was small. Another one is reported by Dr. Goodhart[4] as a case of cirrhosis of the liver, probably originating in phlebitis of the portal vein. Microscopical sections of the liver were shown from a woman aged 21, who in May, 1883, vomited a large quantity of blood. Diminution of the size of the liver, with splenic enlargement, came on; but on death following, only a partial examination of

[1] *J. Anat. & Physiol.*, 1882, xvi. 208.
[2] *Lancet*, 1874, i. 1. [3] *Dublin J. M. Sc.*, 1877, lxiv. 457.
[4] *Tr. Path. Soc. Lond.*, 1889, xl. 134.

the body appears to have been made, for "the portal vein trunk was not examined." It certainly seems strange to ascribe the cirrhosis to a thrombosis which possibly was never present, and certainly was never looked for.

Dr. Moorhead [1] records the case of a man aged 57, who died of hæmatemesis, and at the *post-mortem* examination the liver was normal in size and appearance—the spleen enlarged to three times its natural size. T. B. Peacock [2] remarks on the atrophy of the liver in a case of his—a man aged 52, who died of ascites, diarrhœa, and vomiting,—and believes that the condition was due to the thrombosis. S. West [3] makes much the same remarks on a case of his—a young woman with much the same symptoms as the other cases mentioned.

I think it is evident from these facts that cirrhosis from thrombosis of the portal vein is rare. That to a large amount the liver depends on the blood of the portal vein for nutrition is, I believe, a well-known fact, and should this supply be withdrawn a shrinking of the organ takes place, with impairment of function; the liver is, in fact, starved. The causes which lead to thrombosis are very obscure. In all of the cases except one I have found no reason for the condition is given, possibly because none existed. The only one solitary cause, given in one case, is indulgence in alcohol. The disease comes on apparently from no assignable cause, and usually attacks adults. My case is the youngest patient recorded; most of the others are between thirty and fifty. The course of the disease is towards a fatal issue—no case, so far as I can discover, has been recorded of a recovery. The length of the illness varies, too, considerably. Mine again holds the record for nearly eight years, most of the others are of only a month's duration or only five weeks. The longest after mine is a case recorded by G. Balfour and Grainger Stewart [4] of a young woman who, after a history of ascites for five years, died seven weeks after coming under observation. She probably, from the state of the organs found *post mortem*, had suffered from the disease all that

[1] *Tr. Path. Soc. Lond.*, 1867, xviii. 61.
[2] *Ibid.*, 1873, xxiv. 122. [3] *Ibid.*, 1878, xxix. 107.
[4] *Edinb. M. J.*, 1869, xiv. 589.

time. I see a difficulty in my case, and that is, that the periods of illness were interrupted by months of improving health. What was the condition of the boy's veins during that time cannot be said with certainty; but it is highly probable that the thrombosis existed all that time, and that from some unexplained cause, possibly some extension of the thrombosis, certain symptoms appeared at intervals. It is a point worth noting that no fever existed in any of the cases.

The question of treatment must now be considered, for it is evident that most who saw a case such as this—one with blood being vomited by the pint — would give hæmostatic drugs. As the patient is suffering from rather too much hæmostasis, that hardly appears to be right, yet I believe most would give them. I think we might say this, that drugs which are believed to cause hæmostasis by clogging the blood at the orifice of the vessel might be given with advantage; but those that are intended to act on the vessels, such as ergotine, or on the blood itself, increasing its coagulability, such as chloride of calcium, are counter-indicated.

The blood that was passed by the bowel no doubt came from the congested patch in the intestine, as well as from the stomach. It would be rather a matter of surprise if the veins of the mesentery were not thrombosed when the splenic, into which the superior generally empties its contents, was affected. In my case the inferior was not affected, but in one recorded by Barclay and Holl [1] from the duodenum downwards there was much extravasation of blood, and part of the superior and inferior mesenteric vessels were thrombosed. In Osler's case mentioned before the hemorrhoidal veins were blocked with clot, and in Payne's [2] case the superior mesenteric, and this, according to him, was the oldest part of the clot. The diagnosis, as Osler says, is rarely made, and must always be obscure. I thought in my case that the hemorrhage probably came from an ulcer in the stomach, but I could not account for the ascites or enlargement of the spleen.

[1] *Med. Times*, 1851, n. s., ii. 36.

[2] *Tr. Path. Soc. Lond.*, 1870, xxi. 228.

In the discussion which followed the reading of Dr. Rogers's paper, Dr. F. H. EDGEWORTH said that the chief difficulties of the case lie in the causation of the first thrombosis, which cannot have been due simply to the chlorotic condition of the blood or to the excess of the white corpuscles, but rather to some cause which produced both this and the thrombosis. It is a little remarkable that the thrombosis began in the splenic veins, for the spleen is probably an organ where a certain amount of disintegration of blood-cells goes on, and it was shown that tissue-fibrinogens will, if injected into the blood, cause an intra-vascular coagulation limited to the portal area. It is possible then that the thrombosis in the splenic veins was due to substances produced in the spleen by excessive or abnormal disintegration of blood-cells, brought about by the same cause which produced the alteration in the constitution of the blood. The changes in the blood and lymph-glands which have been observed as a result of excision of the spleen were not present in this case, unless the excess of leucocytes can be so regarded. This is probably due to the fact that the spleen was only slowly and incompletely put out of circulation owing to the opening out of new channels.—Dr. T. FISHER stated that he had seen a case diagnosed during life by Dr. Goodhart. In that case, in addition to hæmatemesis and ascites, there was a venous hum over the spleen. Dr. Fisher asked Dr. Rogers if there was any sign of re-establishment of the circulation through the thrombosed vessels to account for the temporary improvement.—Dr. ROGERS, in reply, stated he had not come across the report of Dr. Goodhart's case. There did not appear to be any attempt to compensate for the thrombosis except in the spleen, to which he had called attention.

## A CASE OF EXTREME BRADYCARDIA.

BY

R. GEORGE FENDICK, M.R.C.S., and GEORGE PARKER, M.D. Cantab.

WITH NOTES ON THE EYE-SYMPTOMS
BY F. RICHARDSON CROSS, M.B. Lond., F.R.C.S.

ALTHOUGH instances of abnormally slow pulse are by no means rare, we think that the following case has some special features of interest which justify our recording it; especially as so little is known of the pathology of this phenomenon, that it is desirable to collect as fully as possible the actual facts observed in well-marked cases.

It is generally granted that bradycardia is a symptom of

various affections, and not one peculiar to a single disease. These affections may be either extra-cardiac, or those of the heart itself, or there may be a combined lesion such as the arterio-sclerosis of the heart and medulla oblongata postulated by M. Huchard[1]; and there is often extreme difficulty in deciding where the cause of the condition really is, a difficulty which was felt by us in the present case. Most remarkable, too, is the slowness of reaction to cardiac stimulants. Alexander Morison mentions that no effect was noticed for some hours after he injected about twenty minims each of liq. strychninæ and of the tinctures of digitalis and strophanthus, besides nine minims of tincture of belladonna.[2] We noticed a similar lack of response to doses or injections of ether and strychnia, though we could find nothing in the cardiac sounds or the area of dulness to indicate a degenerate muscle, and the rate would rise to the normal of itself after a varying period. Yet in such instances no one can lightly regard the serious alternatives of letting a patient die at once from cerebral asphyxia, or of administering almost fatally strong stimulants. When the heart-beats sink, as in our patient, to 11 or 12 in the minute, it is clear that little is needed to put an end to them altogether. An extremely slow pulse, however, is not always incompatible with prolonged life if due care be taken. Occasionally it seems to be the normal condition in persons who otherwise enjoy good health, and, putting aside the perhaps doubtful cases of Napoleon and Colonel Townshend, instances may be found of individuals who have lived for a long period with pulses of 30 or 40. We know one man now living whose pulse for some time remained about 28.

It is curious how little effect on the general health may be caused by the bradycardia. In the present case there was for a long period neither œdema nor dyspnœa; the colour of the face, the general nutrition, and the mental faculties remained unaltered. He was seen at various times by different consultants, none of whom observed any certain signs of

[1] *Maladies du Cœur*, p 324; quoted by Morison, *Treatment*, 1899, ii. 97.

[2] *Loc. cit.*

cerebral tumour or detected any valvular disease. The notes of the remarkable eye changes, including altitudinal hemianopsia, have been kindly given by Mr. Richardson Cross, whose diagnosis of the brain condition was verified *post mortem.*

The following is a brief history of the case:

A. G., 58, a civil engineer, a man of stout build, looking older than his years, but of temperate habits, had served in the North-Western Provinces of India in early life, and was still engaged in business at home. He was of fairly active habits, and usually enjoyed good health, though we noticed afterwards a gummatous cicatrix in the liver. For ten or twelve years he had complained of failing vision and attacks of giddiness, and showed a marked arcus senilis. In April, 1894, he suffered from sudden vertigo with severe syncopal symptoms, from which he did not recover sufficiently to return to business for some weeks. After this his health was never quite as good as before. Any prolonged strain on the eyes brought on minor attacks of vertigo, but careful and repeated auscultation about this time revealed no valvular lesion or change in the pulse. There was never any trace of albumin in the urine, the lungs were normal, and the liver seemed a little enlarged. In February, 1897, he sent for Mr. Fendick, his usual attendant, early one morning complaining of faintness. His pulse was found to be only 40 beats to the minute; but within two hours it rose to 80, and fluctuated for the rest of the day between 35 and 88. He was kept in bed for some days, and gradually recovered so far as to be able to get out of doors.

On April 19th his pulse was found to be as low as 30 at 8 a.m., and about this time a very slight transient epileptiform convulsion was noticed after each slowing of the pulse. This was at first limited to the muscles of the throat; but later on it spread to the face and upper part of the body, and was accompanied with momentary unconsciousness. Later in the day of the 19th of April the pulse sank to 24, and remained at an average of 30 till 5.30 p.m. on the 20th. It was intermittent, and this increased whenever he attempted to sleep. For some days he remained restless, breathing heavily, with an average pulse of 68. Throughout the illness no difference was observed by either of us between the rate noted at the wrist and over the cardiac region. Scarcely a day passed at this period without epileptiform convulsions more or less severe, sometimes during sleep, and accompanied by a marked slowing of the pulse and intermittency.

On May 13th, at 1.30 p.m., the pulse fell to 24, and by three o'clock rose to 94. During the night there were frequent convulsions, and the pulse fell to 20 for some hours, becoming markedly irregular. The next day the rate fell to 16, and again showed intermittency, rising to the normal on the 15th, but it fell again to 20 the day after. He remained in bed, but fairly well, till the 27th May, when other attacks followed with a rate of 24.

During June he was practically free from trouble; but a fresh series of attacks commenced on the 10th of July, and lasted for some days, with a pulse varying from 20 to 72. The patient then gradually improved, and went to the seaside for some months, returning sufficiently well to resume the management of his business. He persevered with this for the first six months of 1898.

In July the old condition returned; the pulse varied during the latter half of the month from 16 to 80, with a large number of epileptiform attacks of greater or less severity. Many of these occurred immediately upon waking, before he rose in any way from the recumbent posture, and for some days the seizures came on hourly. The mental faculties were perfectly clear, but he was very anxious and apprehensive of approaching death. He took food fairly well, and the body appeared well nourished. The bowels were regular, but he was troubled with considerable flatulency and distension. Occasionally laboured respiration was noticed during sleep. Numerous drugs were tried with little or no success, including various cardiac stimulants, as well as bromides and iodides in large doses, which he had also taken in former years.

He improved for the first ten days of August, the pulse remaining at 70; but he continued weak and very fearful of moving lest another attack should come on. Afterwards mental confusion and wandering began to appear. The pulse fell to an average of 22 on August 11th, and on the 13th it sank to 16. Some difficulty in swallowing was experienced, and definite Cheyne-Stokes respiration followed. After a pause of fifteen seconds, five deep inspirations would be succeeded by twice the number of shallow ones.

On the 15th, after a period of normal pulse-rate, fresh attacks came on, while the heart varied from 15 to 30 for twenty-four hours. Some twitching now occurred in the left hand; the patient began to refuse food, and became excited and slightly delirious. On the 18th the pulse again fell to 22, then to 14, and finally reached 11 beats per minute before midnight. It remained at nearly the same rate for four hours. Respiration was laboured, cold sweats appeared on the face, and neither injections of ether or other measures had any effect. Rectal feeding had to be resorted to, and the urine was drawn off by a catheter on the 19th for the first time. The pulse ranged from 14 to 30. On the 20th several seizures took place; but the pulse improved slightly, and even reached 70 at one time. The patient was evidently sinking; breathing became rapid and the temperature febrile. This was as high as 101.6° on August 21st, when the respiration rose to 60 and the pulse ranged from 25 to 60. He became gradually comatose, and died the same evening.

A necropsy was kindly permitted, and carried out under some difficulties. The body was well nourished; the digestive organs, the kidneys, and the lungs presented nothing of interest except the cicatrix on the liver and some degree of emphysema in the lungs. In the brain there were marked patches of atheroma in the vessels of the base, but otherwise the conditions were normal. No tumour, softening, or trace of hemorrhage could be found. A portion of the medulla was hardened, and examined microscopically. The walls of the vessels were considerably thickened, but no definite changes were observed in the other tissues. The heart was of normal size, and the valves perfect; but the walls showed two or three areas where fibroid degeneration was present. One of these in the ventricular septum near the base formed a nodule readily perceptible to the finger. The aorta was healthy; the coronary arteries were affected by atheromatous degeneration to a slight degree, but there was no thrombus or obliteration of their channels. Microscopically the muscle varied, being quite normal in one place, while in another advanced fibroid changes were present. Thus in part of the septum healthy muscle fibres had almost disappeared.

NOTES BY MR. F. RICHARDSON CROSS.

I saw Mr. A. G. with Mr. Fendick on April 1st, 1886. His right eye was sound and the vision good. In the left there was well-marked optic neuritis, and the very unusual phenomenon of altitudinal hemianopsia. The lower half of the field of vision was lost, central vision was useless. He could see no objects with this eye except by lowering his head and getting them in the upper part of the field, where he could still see them. This was due to a lesion in the upper part of the optic nerve, not to a cerebral condition. Large doses of iodide of potassium somewhat improved the vision. On July 23rd I found the left nerve atrophied. There was loss of the lower half of the field of vision now in both eyes, and the patient saw very badly indeed. The right eye had well-marked optic neuritis.

October 20th.—Both optic nerves showed post-neuritic atrophy; vision—R $\frac{6}{24}$, L $\frac{6}{24}$.

April 19th, 1894. I saw the patient at his house. He had been very ill for a fortnight, with difficulty in walking, giddiness, and nausea. The hemianopsia had scarcely altered. The function of the macula lutea of the right eye was active, that of the left impaired. Each eye saw $\frac{6}{18}$. Double optic atrophy, no neuritis; patient walked with difficulty, the knee-jerks were exaggerated, otherwise all objective symptoms except vision were normal.

April 13th, 1897.—The patient felt very ill. Pupil movements were normal. Vision—R $\frac{6}{24}$, L $\frac{6}{36}$. Hemianopsia as before, optic atrophy, but no fresh neuritis. There was no special sense trouble except the eyesight. The knee-jerks were exaggerated, cardiac weakness with flushing of the face and faintness. I considered that there was no gross cerebral lesion, but defective cerebral circulation and probably degenerate vessels.

REMARKS BY DR. G. PARKER.

I first saw the patient in consultation with Mr. Fendick in July, 1898, and afterwards at his request took charge of the case during his absence. It might be said that in the absence

of more definite pathological changes we are left in the dark as to the exact production of the symptoms. The case, however, is clearly one of paroxysmal bradycardia occurring in a patient who had fibroid changes in the ventricles and diseased coronary arteries, while the exciting causes of the attacks were probably changes in the cerebral circulation, eye-strain, and digestive disturbances. Thus, in 1897, I find on three occasions attacks were noted as coming on after reading or using the eyes at his office. In the later stages indeed the tendency to seizure was so strong that it is difficult to discover the exciting causes, but the patient dreaded the slightest noise or excitement for fear of a recurrence. In the classical instance related by Holberton,[1] the heart-rate sank to an average of 33 for some years after an injury of the cord and medulla; but upon an attack of dyspepsia or mental excitement this would fall till it reached even 7½ to the minute, and violent convulsions followed. It was in one of these after-dinner attacks that the patient finally died. Sansom,[2] indeed, seems to think that the influence is often in the other direction, and that the dyspeptic cases seen in paroxysmal and sometimes in persistent bradycardia may be caused by extension to other vagus branches of the disturbance existing in the cardiac area.

Now, bradycardia may be temporary or it may be permanent, or it may be paroxysmal, and the question arises whether any one of these is part of a definite group of symptoms, and always dependent on one and the same cause.

It is clear that permanent bradycardia may be found in perfect health, perhaps more often in very tall men, as Seymour Taylor[3] notices, and again in diseases, such as uræmia and chlorosis, where a high-tension pulse exists. It used to be the fashion to ascribe it to fatty degeneration of the heart, and again to fibroid changes, disease of the coronary arteries, or dilated heart, but all of these may be absent in a well-marked case. Austin Flint regards it as due to a brain lesion, others hold that it is often caused by atheroma of the cerebral vessels. Certainly disease of some part of the nervous system, such as

[1] *Med.-Chir. Tr.*, 1841, xxiv. 76.
[2] *Lancet*, 1897, ii. 523. [3] *Ibid.*, 1891, i. 1247.

an injury to the medulla or cord, is often the only lesion we can discover, and it has been said with some probability that the effect is produced by "an accentuation of inhibitory action coming to the vagus by spinal accessory fibres from the medullary centre" (S. Taylor, *loc. cit.*), since it has been shown that permanent slowing is never caused by the vagus alone.

Temporary bradycardia may also be physiological as in parturition, or it may follow after fevers, in various blood states, or from poisoning. Thus Lewin records a rate of 12 in plumbism. In shock or great pain, and in the last stage of organic heart disease, it is also seen, though how caused is doubtful.

Finally, we may have a paroxysmal form as in this case, with some analogies to paroxysmal tachycardia. Generally, however, there is a permanently infrequent pulse, becoming at times extremely slow, as in Holberton's case. It is very rare to find, as in our patient, a rate of 60, 70, or 80, falling in a short time to 20 or 12, and rising as suddenly. Hodgson's[1] showed an average rate of 29, falling at times to 6, with an occasional gap of thirty seconds, ending in convulsions. This appears to have gone on for six months, after which he recovered and remained fairly well for years. Kinnicutt[2] mentions another with a rate of 30 or 40, falling to 13 and 7; Jacobi one of 12, dropping to 7. R. T. Bruce[3] reported one recently where the pulse was about 20, but for two days before death attacks came on with an interval of forty seconds between the heart-beats followed by convulsions. The breathing showed similar intervals, which curiously resembles Col. Townshend's condition. Adams's celebrated case must be included here.[4] For seven years the rate was usually 30, but a further fall would occur, followed by convulsive seizures, from time to time. There were atheromatous and fatty changes present, but their importance is uncertain.

It is possible that all cases of the Stokes-Adams pheno-

[1] *Brit. M. J.*, 1891, i. 760.
[2] *Tr. Ass. Am. Physicians*, 1889, iv. [3] *Scottish M. & S. J.*, 1898, ii. 330.
[4] *Dublin Hosp. Rep.*, 1827, iv. 353.

menon have this temporary fall of rate, but many reports omit the pulse-rate before and after the seizures. I find only the permanent rate given by Stokes himself,[1] so that it is impossible to say whether his instances were paroxysmal or not.

The phenomena in question may vary from simple vertigo or syncope to strong convulsions and prolonged unconsciousness. True epilepsy is occasionally followed by a very slow pulse; but these convulsions are caused by the slowing through the cerebral anæmia induced by it. One of Stokes's patients could stop them by going on his hands and knees and hanging down his head — the Indian fashion of stopping a fainting attack.

Another point is the long duration of these cases. Mr. Fendick noted pulse-changes for two years and vertigo for ten, and I have given other instances of even longer periods above. Hodgson's patient was alive four years after the attacks, and seems to have recovered from them entirely, though the pulse remained at about 32. The combination of Cheyne-Stokes breathing with paroxysmal bradycardia has been referred to both in our own history and in Bruce's, while Seymour Taylor mentions an instance where the same rhythm was seen in the pulse as in the breathing, and passed away when that improved. Stokes supplies no data as to the pulse in the case which has given the name to the affection, though it appears in his paper on slow pulses. As the combination is so rare, I cannot think that any strong argument can be based on it in favour of the cause of paroxysmal bradycardia lying in the central nervous system, though on the whole the evidence seems to point in that direction. Grasset and others[2] assert that the Stokes-Adams phenomenon may be due to changes in the cerebral vessels alone. Cardiac disease probably plays a part in some cases. Thus the fibroid infiltrations in our case are curiously like those detailed by Ogle[3] in four instances of bradycardia, one of which

[1] *Dublin Q. J. M. Sc.*, 1846, ii. 73.

[2] Clifford Allbutt's *System of Medicine*, 1899, vol. vi., p. 341.

[3] *Lancet*, 1897, i. 296.

suffered from convulsions. Masses of fibroid infiltration were found in the septum and bases of the ventricles; but there is, after all, no proof that the intra-cardiac ganglia were weakened by them, and that unusual effect was thus given to the inhibitory impulses of the vagus. Such changes are, I think, found in many cases where the pulse is unaltered.

## A CASE OF DISLOCATION OF THE HAND AND CARPUS BACKWARDS.

BY

TRAFFORD MITCHELL, M.D. Glasg.

ON 23rd August I was called to see M. J., a boy aged 13 years. Whilst crossing an earthen embankment five feet high on his way to fetch water, his foot had caught in a wire on the top of the embankment, and he had fallen to the ground with his right hand under him, the back of the hand being downwards. When he got up again he found himself unable to catch hold of the tin vessel he had been carrying. He then returned home, and fainted on account of the pain. I found both bones of the right forearm perfectly sound, of normal shape, and free from crepitus; but on the dorsal aspect I found an abrupt projection, which, I soon discovered, was due to the carpus overlapping the lower end of the radius, whilst the lower part of the latter bone projected on the palmar aspect. There was shortening of the limb below the elbow. By traction on the hand and gentle pressure on the carpus, all deformity disappeared, and the pain immediately ceased. There were a few abrasions on the back of the hand, and a little discolouration was subsequently visible in the neighbourhood of the wrist. The treatment employed consisted only of the application of a little liniment and a narrow flannel bandage, splints being found unnecessary. The wrist is now as strong as ever, and free from deformity.

# Progress of the Medical Sciences.

## MEDICINE.

In continuation of our former report (pp. 36–41) on the *rôle* of **milk in the production of tuberculosis**, a paper by Dr. Leonard G. Guthrie[1] is of interest. The following is a synopsis of his

[1] *Lancet*, 1899, i. 286.

conclusions:—1. Thoracic tuberculosis in children is more common than abdominal in the proportion of three to two. 2. Tabes mesenterica, as a cause of death in young children, is practically unknown. 3. The preponderance of thoracic over abdominal tuberculosis is not necessarily and solely due to the direct entry of bacilli into the air passages. In addition to this mode of infection, the lungs may be affected—(*a*) by bacilli entering the thoracic glands through the lymphatics of the pharynx, tonsils, and œsophagus above, and through the lymphatics of the intestines and the abdominal glands below; and (*b*) by the entry of bacilli through the thoracic ducts into the pulmonary circulation *viâ* the right heart. 4. Primary infection through the alimentary tract does not prove that food has been the sole source of evil; therefore tuberculosis in children is not likely to be materially checked by purification of the milk-supply alone. 5. The alleged increase of tuberculous meningitis of late years is probably due to pulmonary tuberculosis set up by severe epidemics of measles. Sims Woodhead[1] reports a large number of experiments in which it had been shown that milk had set up tuberculosis of the tonsils. It had been known for a very long time that pigs fed on tuberculous milk invariably developed a swelling under the jaw, but it was some time before attention had been drawn to the fact that apparently the invasion of the tubercle bacillus was through the tonsils. This mode of invasion had, perhaps, more to do with pulmonary tuberculosis than was sometimes imagined.

A year ago we directed attention to Gardiner's researches[2] on the **immunity from phthisis at high altitudes**, and from a perusal of such books as that of Solly[3] and of Weber,[4] we were almost led to the belief that high altitude is the one thing needful for the cure of tubercular diseases of the lungs; but now all this is changed. *The Practitioner's* new crusade (June, 1898) has been taken up so vigorously that now **sanatorium treatment** is everything, and altitude is nothing. Allusion was made to this matter recently,[5] but I make no excuse for again recurring to the topic, in which at present the whole world is keenly interested.

A publication of the views of a non-medical Nordrach patient, in the *Nineteenth Century*,[6] has been followed by a reply from Dr. Sinclair Coghill,[7] and again by a rejoinder from Mr. James Arthur Gibson.[8] These have been widely read, and all the world now inclines to the belief that medicinal treatment and climatic treatment are nothing in comparison with the methods associated with what is known as sanatorium treatment. These have been summarised in an excellent monograph,[9] and

[1] *Brit. M. J.*, 1899, i. 1038. [2] *Bristol M.-Chir. J.*, 1898, xvi. 127.
[3] *Medical Climatology*, 1897. (See p. 145 of this number.)
[4] *The Mineral Waters and Health Resorts of Europe*, 1898. (See p. 146 of this number.) [5] *Bristol M.-Chir. J.*, 1898, xvi. 235.
[6] 1899, xlv. 92. [7] *Ibid.*, 304. [8] *Ibid.*, 389.
[9] *Sanatoria for Consumptives*. By F. R. Walters. 1899.

here we find an account of some forty or more sanatoria, in various parts of the world, in which more or less successful results have been obtained at various altitudes, and some of them at comparatively low levels.

The essential and one common factor of treatment in all these results is the **open-air treatment**, and this has been well described by Dr. Burton-Fanning.[1] He admits that there is nothing new in the idea that a large percentage of phthisis cases should be curable, nor is there anything new in the vaunting of an open-air life for consumptives; but he adds, "We have failed in our management of phthisical cases through lack of insistance and perseverance." It is claimed that the elevation of the method into a complete system has become needful, and that the essential feature of the "cure" is the perpetual existence of the patient in the open air. "The whole *raison d'être* of these establishments is the practice of this particular cure, and not only do patients go prepared to submit themselves to it, but the whole spirit of the place and its equipment make the adoption of the routine an easy matter. The same broad principles govern the treatment at all these Continental sanatoria for consumption. . . . The *rationale* of this treatment lies in the removal of the patient from those conditions which favour the activity of the tubercle bacillus, while at the same time his constitutional resisting powers are sought to be increased in every conceivable way, to the end that he may successfully repel the attacks of his destroyer. . . . Seeing that the greater number of sufferers from consumption cannot avail themselves of the treatment which is offered abroad, and that in the case of those more fortunately situated banishment to a foreign land often involves many unnecessary hardships, the necessity for establishing sanatoria at home is manifest."

A writer in the *Medical Magazine* (April, 1899), on the *régime* of the Victoria Hospital for Consumption, Edinburgh, remarks: "The usual type of a tuberculous case is quite modified by open-air treatment. In an uncomplicated case the temperature remains subnormal. Night sweating is absent, cough is absent, dyspepsia is absent. Dr. Philip explains the usual cause of cough to be **irritation from vitiated air.** The same cause is to be assigned to the night sweating, $CO_2$ stimulating the sweating centre. It seems a very rational treatment to avoid the presence of the $CO_2$ in the air by plenty of fresh air in the room, rather than to be obliged to give a respiratory stimulant such as the usual picrotoxine, to get rid of the $CO_2$ in the body. Instead of having *dyspepsia*, patients begin to lay on weight rapidly. One patient had been in but three days who had already gained 1½ lb. In connection with weight, two types of patient were shown—the thin patient who put on flesh rapidly, and the fat, flabby patient who did not gain weight, but whose muscles

[1] *The Year-Book of Treatment*, 1899, p. 55.

began to feel firmer to the touch. The gaining weight was the good symptom in the former, the firming up the good symptom in the latter."

Dr. Pott describes the usual routine as follows[1]:—A patient comes for treatment. He has come shivering from his fireside, where he has been treated like an exotic, subject to chills and draughts, and breathing bad air. The first thing to do is to acclimatise him to live in a room in which there is a brisk fire, but in which the windows are gradually opened wider and wider, until at length he is accustomed to them being wide open all day. Having arrived at this stage, a fine day is chosen, and the patient, warmly wrapped up, is taken out into the balcony, and lies on a couch in a horizontal position, sheltered from the wind and rain, and basking in the sunshine. He is kept warm, plentifully fed with stimulating food, and provided with light occupation and congenial society. At first the period in the open-air is short, but it is lengthened until the patient is quite accustomed to spending the whole day in that way. The bedrooms are light, roomy, and well ventilated, and numerous well-thought-of ideas for the thorough continuance of the treatment and care of the patient are carried out under constant supervision. Breakfast is taken with open windows, and there are no special restraints or fussy rules to vex the residents. Caps and overcoats are worn indoors if required, and in fact, to use Dr. Pott's own words, "The regulated daily life of each patient is ordered with a view to getting well and learning to keep well." "The objects of the treatment are to combat the wasting and fever of the malady by the use of an excess of pure air, hygiene, a suitable and very full diet, regulated exercise, and rest."

It is admitted by Dr. Walters that "those who try to live in the open air in a climate like our own will meet with many difficulties, owing to the absence of special shelters and contrivances for warding off rain and wind while admitting fresh air." The credit of showing how this may be accomplished belongs mainly to Brehmer, Dettweiler, and their followers, and the essence of their methods is the elimination of haphazard treatment and the prescription of absolute repose or of various degrees of exercise, according to definite medical indications. "Patients who are febrile muts be kept at rest; if persistently febrile or with high temperatures at night, absolute rest in bed is needed, windows being kept open, or the bed wheeled on to the balcony according to weather and season and other indications."[2]

In spite of all the difficulties in carrying out open-air treatment in this country, Gibson says,[3] "As to a site for the sanatorium. Go to the highlands of Scotland, the lowlands of England, or to the bogs of Ireland, and plant your

[1] *Guardian*, January 21, 1899.
[2] Walters, *op. cit.*, p. 38. [3] *Loc. cit.*, p. 400.

sanatoria there—it is of little consequence where. I see many doctors, leaders of public thought on matters of health, still coquetting with climate. *Climate has nothing to do with the matter.* All that is *absolutely* necessary is (1) a spot in the country where *pure* air is to be had, (2) well away from smoke, dust, traffic, and excitement, where the patients may lead the quiet unconventional lives so necessary to their well-being; (3) the proper treatment, and (4) (but most important) the man to honestly carry it out. *These four things are indispensable,* nothing else is. . . . When it has been proved beyond doubt that consumption is quite as curable at home, on these lines, as it is abroad, it will be the duty of the State to undertake such measures as may be necessary for the cure, prevention, and final eradication of this disease." We fear that this time is yet far distant, and that the views of the enthusiast must as yet be accepted with some reservation. The diet in the sanatorium is one of the most essential elements of what Walther speaks of as the **proper treatment.** "*The movement in this country will succeed only in so far as it follows Nordrach lines,*" says Gibson. All writers are agreed as to the necessity of good food, and a special kind of feeding is adopted at the different sanatoria on the Continent. The weight is usually taken every week regularly, and "if the patient does his duty, gains of from one to four pounds should be made weekly."

The method of forced feeding—the Debove method—was in frequent use some fifteen years ago, but now we hear little of it. This method is advised by Wilcox,[1] more especially for cases of tuberculous laryngitis. Wilcox recommends the separation of the meals into those containing the bulk of the starchy food and meals containing the bulk of the proteids. As a rule, the object at the various sanatoria is to get the consumptive to eat the maximum amount of nutritious and fattening food that can be tolerated, but the end is gained in slightly different ways at different places. The ingestion of this large quantity of food is helped by force of precept and influence, but the great promoter of appetite is fresh air.[2]

**The results of sanatorium treatment** appear from the published statements to be eminently satisfactory. They have been summarised by Walters,[3] but it is very difficult to make any comparison between institutions so variously situated. "Generally speaking, one may say that from one-fourth to one-third of the patients treated in sanatoria are practically cured, or a still greater proportion if they are treated in an early stage. Probably systematic and prolonged treatment from an early stage would restore to health from one-half to two-thirds of our consumptive patients, even without the advantage of an Alpine or other high altitude station. Unfortunately, it is quite out of the question to expect patients to submit to more

[1] *Med. News,* 1898, lxxii. 586.
[2] *Year-Book of Treatment,* 1899, p. 58. [3] *Op. cit.,* p. 49.

than a few months' treatment in a sanatorium, so that we must trust to the educational influence of the sanatorium to complete the recovery of those treated in it. . . . The good results of treatment are permanent in a large proportion of cases."

Gibson claims for Nordrach that the type of cases taken comprising all stages and including many failures from other sanatoria, the percentage of cures amounts to 30, that of nearly cured 65, leaving a balance of only 5 per cent. not improved. . . . "Of the twenty-two cases that I have known who went out to Nordrach from this country within the last four years, twenty were cured of consumption, one died from another cause, and the remaining one might have been cured if an operation on the lungs had been consented to by the patient's friends. . . . I have erred, I think, on the safe side in saying that Walther cures 90 per cent. of his cases."[1] These are the words of a grateful enthusiast who has been cured of his disease, but it yet remains to be demonstrated whether results like this can be achieved under any conditions in the climate of the British Islands.

In spite of the generally accepted view that the **notification** of phthisis is impracticable, a paper by Dr. Newsholme[2] points out that, so far as the patient is concerned, notification need imply, and ought to imply, nothing beyond sending him a precautionary circular, and that small difficulties of detail need not embarrass us. "If notification is desirable in the interests of the public health it should be adopted and a desirable principle is never impracticable." Hitherto the Local Government Board has not been convinced, and hence there is no need as yet to determine what limits to official action after notification are desirable.

R. SHINGLETON SMITH.

## SURGERY.

The best method of dealing with the **pedicle** after the **removal of uterine fibroids** by cœliotomy is still undecided.

Mr. Bland Sutton, in a paper read before the Obstetrical Society of London,[3] on 28 cases of hysterectomy with intra-peritoneal treatment of the pedicle, strongly advocates that method. His results—only 2 deaths in 28 cases—are very good; but we must remember that he lays it down most distinctly that all fibroids should be removed just as all ovarian cysts ought to be, and therefore he is likely to have a series of less formidable tumours than those who only operate when the tumour is growing very large, or causes considerable distress or serious hemorrhage. His contention that his mortality in these cases is as low as after ovariotomy is hardly correct, for—as pointed out by one of the speakers in the debate on

[1] *Loc. cit.*, p. 396. [2] *Lancet*, 1899, i. 279.
[3] *Tr. Obst. Soc. Lond.*, 1898, xxxix. 292.

his paper—7 per cent. for ovariotomy is rather high at the present time, and if operating in all cases gives a mortality of 7 per cent. it would probably be considerably higher with surgeons who only operate on very large tumours, or those causing pressure symptoms and hemorrhage, and it is only on such tumours that the majority of surgeons and gynæcologists operate.

Moreover, Mr. Meredith (one of the surgeons to the Samaritan Hospital), at the same meeting of the society, referred to [1] his own results with the extra-peritoneal method, and they give a lower mortality than Mr. Bland Sutton's. Mr. Meredith had a run of 30 cases treated by the extra-peritoneal method without a death, and two series of 40 and 47 cases respectively with but two deaths in each, and 83 recoveries out of a total of 90 cases—results which, he says, "have not as yet, so far as I know, been equalled by advocates of the intra-peritoneal method;" and Mr. Meredith is not a surgeon who operates on uterine fibroids without special reason, and therefore would not have such simple cases to deal with as Mr. Bland Sutton. Mr. Knowsley Thornton (also surgeon to the Samaritan Hospital), in an article on hysterectomy,[2] says that, putting on one side cases in which large fibroid tumours burrow in the broad ligament or under the parietal peritoneum as a specially difficult and dangerous class of cases, in his practice cases treated by the serre-nœud had a mortality of only 8 per cent., as against 50 per cent. in cases treated by the intra-peritoneal method.

There is always a risk of injury to the ureter in the intra-peritoneal method; and, if the uterine arteries are not efficiently secured, of hemorrhage also, and the ligation of the uterine arteries may not be an easy matter in cases in which the tumour burrows in the broad ligament, and in such cases the ureters would be in special danger. Although in the extra-peritoneal method a slough is produced by the wire of the serre-nœud, yet this slough is not offensive, but tends to dry up if properly treated, nor is there any risk of peritonitis from it, for if it is rightly placed with regard to the peritoneum the peritoneal cavity is safely shut off before suppuration begins around the constricted portion of the pedicle. There certainly is no evidence that peritonitis has ever been produced by dragging on the pedicle. Hemorrhage after the operation, from slipping of the wire, would be an accident due to its improper application. In the intra-peritoneal method there is always a possibility of infection of the peritoneum from the opened uterine cavity, and some surgeons have applied the cautery or strong antiseptic to the cervical canal to prevent this. For in writing of the intra-peritoneal method, I refer to that originally practised by Baer,[3] and now employed by Bland Sutton, in which

[1] *Tr. Obst. Soc. Lond.*, 1898, xxxix. 306.
[2] Clifford Allbutt and Playfair's *System of Gynæcology*, 1896.
[3] *N. York J. Gynæc. & Obst*, 1892, ii. 986.

the cervix is left without ligation, and the bleeding from its surface controlled by previous ligation of the uterine arteries. Complete removal of the uterus, with its greater risk of injury to the ureters, seems unnecessary. But the extra-peritoneal method necessitates a more tedious recovery than the intra-peritoneal method, and this is really the chief objection to it. On the other hand, to rapidly complete an operation for the removal of a very large tumour, or to avoid the risk of injury to the ureters in cases in which the tumour has opened up the broad ligaments near the cervix and thus left little room for ligation of the uterine arteries, the extra-peritoneal method has distinct advantages.

The publication of one case treated by either method is, of course, of little value as an argument for its general adoption; but to show that the results of the extra-peritoneal method are not so dreadful as some writers have represented, I will briefly refer to some details of one of my own cases.

The tumour reached across the abdomen from one anterior spine to the other, and extended two inches above the umbilicus. After removal it weighed five pounds. It was complicated with a small ovarian cyst. The body of the uterus was buried in the tumour, and I applied the serre-nœud two inches above the vaginal attachment. The operation was performed on July 18th, in the Hospital for Children and Women. She never had a bad symptom. By the 21st the constricted portion of the pedicle was getting quite hard and dry, not "hanging out from the abdominal wall with foul pus discharging from the stump," as the usual condition of the pedicle has been recently described.[1] The serre-nœud handle was removed on the 21st, and the wire and pins later. On September 4th she was discharged; the sinus had not healed, but it closed some time after.[2]

* * * *

The more recently published results of **operations for the removal of malignant tumour** are of much value, especially with regard to the breast and the tongue, and they may be said to be distinctly encouraging; indeed we are now able to speak of long periods of non-recurrence after the removal of malignant tumour in certain parts, in a way never thought of some years ago. This is due to early and free removal.

The average duration of life in **cancer of the breast** not operated on is 2½ years from the time when it is first noticed. The risk of operation is very small. Watson Cheyne[3] has operated on 61 cases with a mortality of only 1.6 per cent., and Halsted on 50 with no death. All these operations were

[1] *Bristol M.-Chir. J.*, 1899, xvii. 9.

[2] Another case, also treated by the serre-nœud, is referred to in my remarks at the May meeting of the Bristol Medico-Chirurgical Society.

[3] *Brit. M. J.*, 1896, i. 390.

extensive ones, including removal of glands. They were, of course, all aseptic. With a very thorough removal of the disease together with the glands, whether palpable before operation or not, out of the 61 cases operated on by Watson Cheyne up to three years ago no less than half are cured.[1] Although the term "cure" as applied to these cases only means absence of recurrence for three years or longer, the further history of the eleven "cured" cases which Watson Cheyne reported in 1896 shows that in only one has there so far been any recurrence of the disease, and in that case it was probably a fresh development, as the patient is reported to have died of cancer of the intestine six years after the breast operation. Halsted (who is Professor of Surgery in the Johns Hopkins Hospital, Baltimore) has recently given us[2] the results of his operations for cancer of the breast up to April, 1898. He says that "of the 76 cases operated upon three or more years ago, 31 (41 per cent.) are living without local recurrence or signs of metastases." His method of operating is even more extensive than Watson Cheyne's, for he removes the greater part of the pectoralis major muscle in every case. Mr. Butlin has practised the method for the last few years, and has had a remarkably successful series of cases, for he had eight cures out of thirteen cases operated on.[3] He regards this as a very fortunate series, and says that he does not expect "that the next or many future series of thirteen cases will yield nearly such good results"; but it shows what operation can do for cancer of the breast, especially when we note that Butlin says that the cases were not obtained early for operation; "there is scarcely one in which the disease was not known to have existed several months, and there are many in which it had existed for one, two, three, or more years. There were many in which the axilla was full of cancerous glands, and several in which the primary tumour was ulcerated." Warren[4] has also had 17 cures in 72 operations, or about 25 per cent. I have not yet followed up the histories of all the patients I have operated on for cancer of the breast—and I have always operated in the thorough way that Watson Cheyne does,—but I know of a few cases free from disease more than three years from the operation. In one case, after three years from the operation, there has twice been very slight local recurrence in the neighbourhood of the scar. These recurrent growths have been removed.

The chance, then, of prolongation of life, and even cure of the disease, is so good, that we can unhesitatingly advise operation, which must be of the thorough or so-called "complete" kind which Watson Cheyne practises, and which he has described in his Lettsomian Lectures,[5] and has more recently referred to his paper in the *Lancet*.[6]

[1] *Lancet*, 1899, i. 756. [2] *Tr. Am. Surg. Ass.*, 1898, xvi. 162.
[3] *St. Barth. Hosp. Rep.*, 1899, xxxiv. 49.
[4] *Boston M. & S. J.*, 1898, cxxxix. 186. [5] *Loc. cit.* [6] *Loc. cit.*

The only question which remains to be considered is, What are the **contra-indications to operation?** Watson Cheyne gives them as follows:[1] 1. Cases of cancer *en cuirasse*. 2. Cases where there is a large mass in the axilla involving the nerves. 3. Cases where large glands can be felt above the clavicle. 4. All cases where secondary cancers already exist elsewhere. He has removed a portion of the axillary vein several times when involved in gland growth, and once a portion of the artery and vein, without any harm resulting. I have myself also more than once removed portions of the axillary vein with the gland-growth without any harm resulting. Halsted[2] does not now consider enlargement of the supra-clavicular glands a contra-indication to operation, and he clears out the supra-clavicular region thoroughly in every case. He has records of two cases on which he operated for removal of supra-clavicular glands which appeared after the breast and axillary contents had been removed, in which there was no recurrence three and a half years after the supra-clavicular glands were excised. Halsted says: "In one of these latter cases I considered the prognosis desperately bad, at both the infra- and supra-clavicular operations. At the first operation the cancer had infiltrated the axillary fat diffusely, and could with difficulty be separated from the subclavian vein; at the second operation the same desperate state of affairs was encountered in the neck."

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The results of operations for **cancer of the tongue** have been considered in recent papers by Watson Cheyne[3] and Butlin.[4] Watson Cheyne, from a study of the statistics of some Continental surgeons, comes to the conclusion that the mortality of excision of cancer of the tongue may be estimated at 15 to 20 per cent., but some surgeons have had a much lower death-rate in a certain series of cases. Thus Kocher had only one death in his last series of 28 cases, and Volkmann only two deaths in 91 cases. Kocher's cures amounted to 18 per cent., Koenig's to 12 per cent. Mr. Butlin's results are particularly encouraging. He has operated on 102 cases, with a mortality of 10 per cent., and 20 per cent. of cures. His private operations—or in other words his operations on cases at an earlier stage than the hospital ones—give the splendid result of only one death in 49 cases, and 13 cures. These operations are included in the 102 already given, and this result is an illustration of the desirability of operating for cancer at the earliest possible moment.

In cancer of the tongue we have a disease which proves fatal without operation in a year to eighteen months, and towards the end is a terribly painful and distressing disease. At a moderate risk—5 per cent. mortality in early cases limited to

[1] *Brit. M. J.*, 1896, i. 387. [2] *Loc. cit.*
[3] *Brit. M. J.*, 1896, i. 449. [4] *Ibid.*, 1898, i. 541.

the tongue, but with 15 to 20 per cent. mortality in extensive cases, in which the disease has extended to the floor of the mouth, palate and tonsils—the disease can be removed with a chance of cure in 20 per cent. of cases (and even more in earlier cases), a chance of prolongation of life by many months in almost 95 per cent. of early and 80 to 85 per cent. of extensive cases.

If recurrence takes place after operation, in many cases it is not in the mouth, where the disease is so distressing, but in the glands of the neck, and such recurrence in most cases admits of removal.

The lesson which a study of recent literature on the treatment of cancer of the tongue teaches most emphatically is, that at the very earliest moment the growth should be removed, and that weeks must not be lost in treating an ulcer of doubtful nature by iodide, when the diagnosis can be established in a few days by the microscopic examination of a portion of tissue snipped off the edge of the ulcer under cocaine.

C. A. MORTON.

## OBSTETRICS AND GYNÆCOLOGY.

**Post-partum hemorrhage** is truly described as *the* obstetric emergency in which prompt and proper action on the part of the attendant is of vital importance to the patient, as the issue will be determined before assistance can be obtained or complicated measures carried out. The rules for treatment therefore should be as simple and widely understood as possible. Too much stress cannot be laid on prophylactic measures. The third stage of labour should be left to nature, but not to nature unwatched and unassisted, the fundus being carefully controlled by light manual pressure until and for some time after the third stage is completed. Unnecessary hurry in this stage is to be deprecated; half an hour is quite an average time. Secondary uterine inertia from exhaustion by prolongation of the second stage and the withholding of nourishment should not be allowed to occur. If extractive manipulations are necessary, they should be conducted in a manner as much like the natural process as possible. In no case should the uterus be emptied between the pains, and the fundus should be followed down by the hand as the contents are expelled. Should inertia be dreaded, strychnia and ergotin, the latter in ¼-grain doses thrice daily, should be administered during the last month.

Delee[1] gives some novel methods of treatment in cases where *post-partum* hemorrhage occurs in spite of all precautions: in the first place, if the third stage has not been completed, and this will usually be the case when the hemorrhage is partly or entirely caused by laceration, the placenta must be at once

[1] *J. Am. M. Ass.*, 1899, xxxii. 802.

expressed or removed by the hand; the uterus being empty, firm bimanual compression is employed, doubling the uterus on itself and closing the cervix. He also recommends compression of the aorta. He then suggests, supposing that by compression the uterus is under control, that it should be plugged with iodoform, sterilised, or borated gauze; in order to do this the anterior and posterior lips are seized with vulsella and the uterus drawn down to the outlet: this proceeding itself is a valuable remedial agent, since traction on the cervix straightens out the vessels in the broad ligament and by putting the tissues on the stretch compresses them: three to four yards of the packing, which should be a yard wide, are then introduced into the uterine cavity until it is filled tightly; if after this proceeding any oozing takes place, he stitches the lips of the cervix together so that the uterine cavity is completely closed. He states that he has found this proceeding of great value.

He mentions the use of the hot douche at 120°F. after it has been ascertained whether the hemorrhage is due to atony or to laceration. We would prefer to reverse the order: the hot douche will almost invariably either stop or cause a great diminution of hemorrhage from either or both of these causes, especially that due to atony; the action of the douche is much increased by the use of half an ounce of ordinary vinegar to the pint; should this not cause cessation, lacerations are probably present, and the uterus should be packed while the lacerations are sewn up. The packing may be left in for twenty-four or forty-eight hours; but if iodoform gauze is used, watch must be kept for the symptoms of iodoform poisoning—namely, headache and rise of temperature, which, if present, will disappear at once on removing the packing.

The suture of the lesion seems rather a refinement: the slight oozing which occurs after packing is often due to uterine contractions squeezing out serum and blood that has been already absorbed by the packing, and if the latter is done sufficiently tightly the hemorrhage will infallibly cease. This method is undoubtedly of the greatest value, and should be employed more frequently as an emergency measure: the hot douche is preferable, as it can be used without removing the supporting and compressing bands for more than a moment, and does not require assistants in addition to the nurse usually present; in any case manual compression and the hot douche will give time for further skilled assistance to be obtained, when the packing can be done.

The sense of security in the mind of the attendant when he has packed the uterus tightly is most gratifying; there need then be no anxiety about recurrence of the bleeding, a state of things which under other circumstances will keep him in a state of anxiety for several hours. In the obstetric department of the Bristol Royal Infirmary this method is looked upon as a routine measure to be adopted in all cases where artificial emptying of

the uterus is resorted to if hemorrhage occurs after it, especially in cases of abortion and miscarriage after the use of the curette. Not only is hemorrhage prevented, but involution is more rapid owing to the securing of the complete evacuation which occurs when the gauze is removed.

* * * * *

The **uterus** is one of the commonest organs to be attacked by **malignant disease**; in fact, one-third of the total cases of cancer occurring in the female consist of those in which this organ is attacked.

The nature of the treatment to be adopted depends on several factors in each case, the most important of which is the stage at which the disease has arrived when the question of the treatment to be adopted first arises, since on this depends very largely its success or failure. As regards treatment, we may at once exclude all other than radical operative measures except in those cases in which the disease is so far advanced that obviously no radical measures will give more than temporary relief, owing to the impossibility of removing the whole of the affected tissue. As regards operative measures, the broad lines of procedure may be briefly laid down as follows: Radical operation should not be undertaken unless there is a reasonable hope that all affected tissue can be removed without causing damage to vitally important organs, or without subjecting the patient to an operation of such severity as to render her immediate recovery unlikely.

Another most important point for consideration is the **prospect of cure**, or the length of time which will elapse after recovery from the operation before recurrence takes place. This practically depends on several conditions: firstly, the possibility of complete operative removal; secondly, the method of performance of the operation; and thirdly, the nature and situation of the growth. As regards operative treatment of these cases considered generally, the prospect here is apparently quite as good if not better than that in cases where other organs are affected which can be subjected to radical treatment, *e.g.*, the breast, tongue, lip, penis, or rectum. Recurrence, after operations on the uterus, does not take place any sooner than, if as soon as, after operations on the above, which are considered the most favourable situations for operative treatment; the immediate mortality is if anything lower than after operations on the above-named other organs; therefore operation may be undertaken under favourable conditions quite as readily.

Even in those cases where after radical operation undertaken for uterine cancer early recurrence takes place, unless this occurs in the peritoneum, the fatal termination is attended with less suffering, while in the interval the patient may be restored

to comparative health by the removal of the sloughing mass, which causes a severe form of septic absorption, with its attendant wasting anæmia and pains.

Halliday Croom,[1] in a paper on **vaginal hysterectomy**, gives a very unfavourable account of his own results from this operation. He is so impressed with the rapidity of recurrence and the great pain suffered by those who die after this operation with secondary peritoneal infection, that he goes so far as to state that although in certain favourable cases recurrence may not occur, or only occur after some years, yet as a general rule recurrence occurs early, and if in the peritoneum the patient's exitus is much more painful than if the growth had not been attacked. It appears to me, however, that it is impossible to say how any given case will terminate; and while it is quite true that in certain cases the rate of progress of the growth is slow, and that the patient may live many months in a greater or less degree of discomfort, at the same time we cannot prophecy as to whether secondary infection of the peritoneum will not take place even if the growth is left alone, and while the fatal result is ultimately certain if the latter plan is adopted, it is equally certain that in cases subjected to radical treatment a certain number will live perhaps for several years in comparative health and comfort. Croom states that of the cases operated on by him, fourteen in number, all were dead within the year—a truly sombre picture, and gives a most gloomy view of the results of surgical intervention in these cases; he quotes the following results from the practice of others, thus: from the statistics of the Dresden Klinik forty-five cases out of eighty were free from recurrence two years after operation; thirty-four out of fifty-eight were without recurrence three years after; twenty-five out of forty-two, four years after; eighteen out of thirty, five years after; six out of nine, six years after; two cases who had survived seven years were quite well; while in Leopold's practice we are informed that seventy-two out of seventy-six of his cases were well and without recurrence from one to five years after operation.

It would appear that Croom takes too gloomy a view of the case, and that it is not justifiable to augur, as he does, that the operative treatment of cancer of the uterus is to be condemned because in a limited number of cases such as his the result as regards recurrence has not been good.

At the eleventh annual meeting of the Southern Surgical and Gynecological Association, held at Memphis, U.S.A., McMurtry[2] read a paper on the same subject, which has a striking similarity to that of Halliday Croom, and described five cases on which he had operated by vaginal hysterectomy during the past year, two of which had recurrence within five months, one in the bladder and one in the vagina; all five appeared to be typically suitable cases for the operation. He

[1] *Edinb. M. J.*, 1898, N.S. iv. 489. [2] *Am. J. Obst.*, 1899, xxxix. 217.

considered it doubtful whether one of the three remaining would be alive three years after operation. He advocated as a preferable measure the removal of the uterus by abdominal section, with a liberal removal of adjacent structures, especially the vaginal wall; he did not, however, advocate removal of the sub-peritoneal glands, as their enlargement was often due to inflammation.

In the subsequent discussion, which brought out strongly the opinion that the negro race is not so little susceptible to cancer as is generally supposed, Howard Kelly expressed surprise at the author's conclusions, and stated that his experience —a by no means small one—led him to quite an opposite opinion, many of his cases of vaginal hysterectomy for cancer having completely recovered and remained well for several years.

Against the gloomy views taken by McMurtry and Croom we may place the opinions and records of F. B. Jessett,[1] who publishes one hundred and seven cases distributed over seven years. We gather from his statements that nine died as the immediate result of operation. He prefaces a very interesting table with some instructive remarks on diagnosis and pathology; he lays great stress on the necessity for the vaginal examination of women who suffer from irregular hemorrhages apart from parturition and pregnancy, and especially of those who so suffer when past the climacteric, or who have any watery or fœtid discharge in addition to the hemorrhage: while this necessity is not recognised, a very large number of cases must go untreated until surgical intervention is useless except as a palliative. He regards malignant disease in its inception as being purely local, and considers that until cellular tissue is invaded the lymphatics are unaffected. As previously stated, nine operations had a fatal termination, not a large number considering the gravity of the operation, and this includes complicated cases. He considers that operation should be limited to those cases in which the mobility of the uterus is not impaired and the broad ligaments not invaded. He does not consider that invasion of the vaginal wall is an absolute contra-indication, nor that it is necessary that the cervix should be able to be drawn down to the outlet, a condition considered essential by some operators. He considers that affection of the iliac glands occurs late in the disease. As regards technique, he is of opinion that the union of the vesical and rectal peritoneal edges by suture is very important, and prefers to use the ligature for securing the uterine and ovarian vessels. He gives the following as the **indications for advising operation**: coloured and offensive discharge occurring in a patient at or past the menopause, and the passing of the sound causing bleeding; if after vaginal examination no growth is felt, dilatation of the cervix, exploration of the uterine cavity, curetting and careful microscopical examination of removed structures; if malignant growth is felt on

[1] *Brit. Gynæc. J.*, 1899, xiv. 541.

vaginal examination, or if the portions removed show malignant tissue under the microscope, he advises hysterectomy.

Of his 107 cases, nine died and recurrence took place in fifty-one, which number includes those lost sight of; forty-seven remained free from recurrence for periods varying from two years in the case of the last series to seven years in the case of the first; his figures as regards recurrence show a striking similarity to those of the Dresden Klinik mentioned above, the percentages being nearly the same. This seems to be, to a certain extent, an answer to Croom's statement, that cancer of the uterus in England and Germany must be two different things.

In the same way that the operation for removal of cancer of the breast has been extended so as to include the clearing of the axilla and removal of the subclavicular glands and tissue, with a marked improvement as regards delaying recurrence, operators are now seeking to apply the same principles to the uterus. To this end Freund's operation is being increasingly performed, with the additional procedure of removing a large part of the pelvic peritoneum together with the glands in the pelvis and the whole of the broad ligaments.

Ries [1] reports fifteen cases treated by the Ries-Clark operation, with three deaths. The **technique of the operation**, which is essentially a panhysterectomy by the combined method, is as follows:—The patient is prepared by a preliminary curetting and cauterisation under anæsthesia, while at the same time the whole pelvis is carefully explored for infected glands. If the growth is within the cervix, the cervical lips are sewn together to prevent contamination; if without, a vaginal cuff is raised and sewn over the cervix. Fresh assistants, instruments, sponges, etc., are provided for the next steps. The patient is placed in steep Trendelenburg position, incision from pubes to umbilicus, and the pelvis palpated carefully to exclude enlarged and immovable glands; these being found absent, the infundibulo-pelvic ligament is ligatured and cut close to the pelvic wall. The peritoneum is then incised along the common iliac artery, and the vessels exposed by dissection until the ureter is reached; the ureter is then exposed in the whole of its length in the pelvis —*i.e.* from the brim to the base of the bladder. Bleeding points are clamped as cut, or ligatured. When the uterine artery comes into view it is ligatured close to its origin, but outside the ureter and by sight; then the whole of the cellular tissue and glands lying between the external iliac artery superiorly, the pelvic wall laterally, the base of the bladder anteriorly, the pelvic floor inferiorly, and the meso-rectum posteriorly, is removed; the last lifted up and freed from all accessible glands. This procedure, begun on the left side, is repeated on the right. Adhesions between uterus and rectum are now divided if present. The round ligaments are secured, and the peritoneum of

[1] *Am. Gynæc. & Obst. J.*, 1898, xiii. 570.

Douglas's pouch incised close to rectum, and the vagina opened; the anterior space being already accessible as far as the peritoneum, the uterus is now free all around and is removed. The pelvis is now closed in by suturing the anterior edge of the peritoneum, which extends from the lateral wall across the vesico-uterine pouch, to the posterior which extends from the lateral wall across the pouch of Douglas; the abdomen is then closed in the ordinary way.

Werder[1] has devised a somewhat similar procedure, with this difference, that instead of by a prolonged dissection removing cellular tissue and glands, although he mentions this as an advantageous procedure, he removes the whole of the upper part of the vagina. He commences in the same way as Ries, but without freeing the peritoneum from the lateral walls of the pelvis, the anterior and posterior cul-de-sacs being opened and the lateral fornices separated from them. Recurrence is known to have taken place in forty-six cases; in twenty-four cases the average time before recurrence was nine months, and the average time before death sixteen months.

The result of an examination of the foregoing appears to be—(1) That the immediate mortality of all cases from the operation may be taken roughly as less than 10 per cent. if vaginal hysterectomy is chosen, but may be expected to be more if the more extensive operations of Ries, Clark, and Werder be undertaken; but if only the most favourable cases be selected, the mortality will not be higher than 7 to 8 per cent. (2) That a restoration to health of a certain duration may be expected in all cases; this may extend from six months to possibly permanent cure. (3) That recurrence will take place in less than two years in more than half the cases subjected to vaginal hysterectomy, and in the greater part of the remainder within five years. (4) That possibly 10 per cent. of cases will survive at the end of six years.

As regards the operations of Ries, Clark, and Werder, further experience is required. The principle seems surgically sound, but we must not expect very striking alterations in the recurrence-rate in view of the large number of cases in which this occurs in the scar, or peritoneum; its benefit is only likely to be gained by lessening the number of cases in which recurrence takes place in the glands, or by extension through and from cellular tissues already partly infected.

Finally, the possibility of this disease being present should never be lost sight of by the practitioner in any case where irregular hemorrhages, apart from the puerperal state, ovarian or fibroid tumours, are present, especially after the menopause, and all women should be kept informed of the importance of early diagnosis and the necessity for physical examination when suspicious symptoms are present. Out of the last fifty cases seen by me, only five were fit for radical operation; in two

[1] *Am. J. Obst.*, 1898, xxxvii. 289.

others an operation was possible, but not likely to give rise to other than the most temporary benefit. This seems to show an appalling state of ignorance, not on the part of the profession, since in all cases the disease had been already recognised, but on the part of the patients, on whom definite and distinct symptoms had not appeared to impress the necessity for seeking advice.

WALTER C. SWAYNE.

## Reviews of Books.

**Lippincott's Medical Dictionary.** Prepared by RYLAND W. GREENE, with the collaboration of JOHN ASHHURST, Jr., M.D., GEORGE A. PIERSOL, M.D., and JOSEPH P. REMINGTON. Pp. xii., 1154. London: J. B. Lippincott Company. 1897.

There seems to be no end to the enterprise of publishers of medical works, for they publish enormous dictionaries which, we fear, can never give an adequate return for the trouble and expense incurred. The one before us is one of the most complete we have seen, and must have involved a great amount of labour in its compilation. We can strongly recommend it to all in need of a good medical dictionary. It is especially strong in the departments of chemistry and materia medica, in this respect excelling most of those with which we are familiar.

**English Sanitary Institutions.** By Sir JOHN SIMON, K.C.B. Second Edition. Pp. xix., 516. London: Smith, Elder, & Co. 1897.

We gladly renew acquaintance in this second edition of Sir John Simon's *English Sanitary Institutions* with this fascinating and instructive history of human sanitary endeavour. The successful writer on matters of universal history must be a man of wide knowledge and of broad mind, able to sift and choose, to prune and criticise, and to weave the disconnected threads of record and tradition into one continuous whole. Sir John Simon has the necessary qualities for the work, and it is fitting that from the pen of so delightful a writer such a volume should appear after a long life of usefulness, happily not yet completed.

The introduction takes us back to "that nebula of times which human records do not pretend to reach," and presupposes that at a very early period when communities began to exist, a desire must have originated "to amend, in the circumstances common to them, the conditions which they found dangerous to their lives." Hence through succeeding phases of

civilisation, from the evidence found amid the ruins of Nineveh, from the records relating to Greece, and through the more pretentious evidences such as the aqueducts and cloacæ of Rome, and the establishment in Rome of a public medical service for the poor, we pass through the darker centuries, the crusades, and the spread of leprosy, and the widespread and disastrous epidemics of the Middle Ages. The efforts of medieval philanthropy to relieve emergencies of distress threatening the poor are duly recognised, and the early and tentative efforts to cope with disease are in turn pointed out. Then it is shown that through the Tudor and Stuart reigns the changes developing later into the beginnings of modern medicine had been tending to define themselves in embryo; and medical science, previously "exercised from the widely different standpoints of the ecclesiastic, the barber, and the grocer," was able to "come into self-conscious existence."

In "New Momenta" we trace the beginnings of modern medicine, accompanying and following the revival of learning in Europe, starting from the fifteenth century, at first vaguely, more definite in the sixteenth century when alchemy made progress in experiments and Vesalius achieved his daring dissections; through the more eventful quickening of the art of medicine in the seventeenth century, signalised in its earlier half by Harvey's discovery of the circulation of the blood, and later by Sydenham's careful and exact observations; leading to the far higher position of the practice of medicine in the eighteenth century, and its still more illustrious development in the present. Briefly, but with due appreciation, are sketched the work of Mead, whose *Short Discourse concerning Pestilential Contagion* gave advice wonderfully in advance of his age, and might even now repay study; Pringle and Lind's work on the Diseases of the Soldier and Sailor; Gilbert Blane's work in banishing scurvy from the navy; George Baker's work on the Cider Colic in Devonshire; and Jenner's imperishable triumph, whose "services to mankind, in respect of the saving of life, have been such that no other man in the history of the world has ever been within measurable distance of him."

And so we pass in chapters of unabated charm through the history of "The Growth of Humanity in British Politics," wherein John Howard's memorable work on *Gaols* is not forgotten; touch on the early experiences of Asiatic cholera in Europe, and reach the commencement of the present reign. Here Sir John Simon is thoroughly at home. Stimulating as it was to trace with him the inception, early beginnings, and gradual growth of preventive medicine, it is still more deeply interesting and instructive to follow under the guidance of his master-hand, and with the sidelight of his ripe experience, the actual growth of the great revival in the care of health which commenced with the reign of Queen Victoria and has progressed steadily, with occasional relapses, but in the main ever making for improve-

ment and for progress. The volume must be read and studied to fully appreciate all the author's conclusions; but it may be stated that, in his belief, "the educational onward impulse" towards development of our sanitary institutions and their administration must come, as it has largely come in the past, from the medical profession. He looks forward with hopefulness, gladdened by "the immense development of altruism," by the "kindliness of man to man," and sees the human race "more and more, as the cycles are trodden," rising "to the religion of mutual helpfulness."

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**Sir Benjamin Collins Brodie.** By TIMOTHY HOLMES. Pp. 256. London: T. Fisher Unwin. 1898.

Mr. Holmes has produced one of the most interesting books yet issued in the "Masters of Medicine" series. It does not perhaps quite equal in interest the *Life of John Hunter*, but it does not fall far short of it. Mr. Holmes thinks that Brodie is to be placed next to Hunter among the celebrated surgeons of the past, and his well-known books, *Diseases of the Urinary Organs* and *Diseases of the Joints* are sufficient to justify this estimate of his work.

We cannot attempt in this short review to give even a brief outline of the events which make this volume so well worthy of perusal. Brodie's character as a man deserves very careful study; and the insight which the book gives us into the condition of the profession and the state of society at the time when he lived is by no means its least instructive part.

Brodie had many interests outside his profession, and his views on various questions of psychology are given by Mr. Holmes. Perhaps the keynote of Brodie's life and work may be found in his statement that "there is no greater happiness in life than that of surmounting difficulties; and nothing will conduce more than this to improve your intellectual faculties, or to make you satisfied with the situation which you have attained in life, whatever it may be." The book will therefore interest the general reader.

The frontispiece is a very beautiful reproduction of a photograph of the portrait of Brodie, painted by Watts in 1860. The photograph was taken by his grandson, the present Sir Benjamin Brodie, to whom the reader is also indebted for much of the information relating to the home-life of the distinguished surgeon.

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**Justus von Liebig: his Life and Work** (1803–1873). By W. A. SHENSTONE. Pp. 219. London: Cassell and Company, Limited. 1895.

Mr. Shenstone deals in popular style with the life-work of one who made no less important contributions to science as a

means of education than to the advancement of his special province—chemistry. Liebig's name will be associated in most minds with the relations of the chemical composition of the soil to the growth of plants; but his establishment of a teaching laboratory, and the dissemination of the results of the researches of master and pupils, have probably had an even more important influence on modern scientific progress.

This biography, which is issued in "The Century Science Series," will be read with the greatest interest by all who are concerned with the foundations of our present knowledge of chemistry in its relation to life, and Mr. Shenstone is to be congratulated on the success with which he has depicted the main scenes in a memorable career.

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**On Certain Problems of Vertebrate Embryology.** By JOHN BEARD, D.Sc. Pp. vii., 77. Jena: Gustav Fischer. 1896.
**The Span of Gestation and the Cause of Birth.** By JOHN BEARD, D.Sc. Pp. ix., 132. Jena: Gustav Fischer. 1897.

The author, in these two essays, puts forward a theory to explain certain phenomena which occur in the process of development of vertebrates. The theory is, that there is a hidden alternation of generations—an asexual larval form, succeeded by a sexual one. To the first belong such structures as a yolk-sac, transient nervous system and notochord, which in all vertebrate groups are found to disappear together and at a period when the embryo is just beginning to assume the body form characteristic of the adult. He calls this time the "critical period," and the interval from fertilisation of the ovum to this a "critical unit."

Monotremes alone of mammals have a well-filled yolk-sac, which is empty in all higher mammals. The cause of this disappearance of the yolk is probably to be found in the development of mammæ so that the young can be born in an early stage, the "critical" one, *i.e.* as soon as they are able to suck. This actually occurs in marsupials, and in such forms no allantoic placenta is ever formed. Most mammals, however, have a longer gestation-period, which becomes possible owing to the development of an allantoic placenta, and in such forms the gestation period is found to be a multiple of the "critical unit;" *e.g.* in the rabbit it is two, in the cow five, and in man six. The development of allantoic placenta renders the development of a marsupial pouch unnecessary.

In the case of some mammals, *e.g.* rabbit, the adult female is always with young, parturition is followed immediately by fertilisation; ovulation succeeds immediately on parturition. In other mammals, *e.g.* pig, lactation abolishes ovulation during its continuance.

The menstrual flow is not equivalent to the period of heat in

lower animals, does not correspond with ovulation; but is to be regarded as the shedding and abortion of a decidua prepared for an egg given off at the close of the preceding menstruation, but which was not fertilised. The ovulation-cycle is equal in length to the menstrual cycle; but the time of ovulation does not correspond with that of the catamenial flow.

The length of the "critical unit" in man is found to be from 45—47 days, *i.e.* twice the ovulation period. Abortions are particularly liable to occur at the end of the first "critical unit," which, according to the theory, represents an important change in the life-history of the individual, that in which the alternation of generations takes place, and at which the allantoic placenta is first formed, nourishment previously to this being obtained through the ecto-placenta derived from the yolk-sac.

The cause of birth is to be sought in a coming ovulation, *i.e.* is due reflexly to the ovary, and the formation of a corpus luteum is to be regarded as a means whereby ovulation is prevented during gestation.

The theory, of which the above is the slightest possible sketch, thus furnishes a clue to many normal and abnormal phenomena of the development of the embryo, and to the various periods at which they do or may occur. Whether it will be substantiated by future research remains to be seen.

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**Atlas of Methods of Clinical Investigation, with an Epitome of Clinical Diagnosis and of Special Pathology and Treatment of Internal Diseases.** By Dr. CHRISTFRIED JAKOB. Edited by AUGUSTUS A. ESHNER, M.D. London: The Rebman Publishing Co. (Ltd.). 1898.

The earlier part of this book consists of 68 coloured plates, containing 182 illustrations, dealing respectively with clinical microscopy, chemical colour-reactions, the normal projection of the viscera upon the surface of the body, and their topography as determined by percussion, together with diagrammatic representations of diseases of the chest and abdomen. The plates are accompanied by descriptive letter-press, the object being to represent in a graphic manner the results of the clinical investigation of diseases by all the above methods. The number of the plates is so large that the microscopy of the blood, urine, sputum, gastric and intestinal contents is fully illustrated; and they are uniformly good, so that, besides being useful to the practitioner for reference, they will doubtless greatly aid the student. The representations of the colour-reactions of the various chemical tests in clinical use will also be helpful. The diagrammatic pictures of abdominal and thoracic affections are taken from typical cases, of which a short abstract faces each plate.

The next portion of the book describes the method to be followed for the complete examination of a patient, and is

followed by a detailed account of the clinical investigation of the systems of the body; of the blood and secretions, and of the chief bacteriological methods of use for direct clinical purposes, together with a short description of the normal state of each system and the chief pathological deviations from it.

Lastly, there is an epitome of special pathology and treatment. This is not so satisfactory as the rest of the book, as it attempts the impossible task of describing satisfactorily in brief abstract the symptoms and signs of disease. This is, however, a small part of the book, which for the rest is excellent, and we can recommend it as a very useful clinical manual of convenient size, and remarkable for the abundance and practical usefulness and beauty of its illustrations.

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**Psilosis or "Sprue."** By GEORGE THIN, M.D. Second Edition. Pp. xii., 270. London: J. & A. Churchill. 1897.

Dr. Thin in this book gives a full account of this disease, for the differentiation of which from other forms of tropical diarrhœa and chronic dysentery we have mainly to thank his clinical acumen. His observations seem to establish the existence of psilosis as a distinct disease. The further question whether some varieties of so-called hill-diarrhœa and of diarrhœa alba met with in India are identical with psilosis is still uncertain, but now that the symptoms of psilosis have been differentiated this point should soon be decided. The exciting cause of the disease has still to be discovered. There is an interesting review of the literature, a chapter on the pathology of the disease, and a full description of the treatment—first advocated by the author,—which has been attended by successful results. A number of cases are reported in an Appendix. The book is written in a clear and interesting style, and gives the reader full information on the subject, which is of practical importance, as any medical man may be called upon to treat such a case in a patient who has lived in tropical countries. Three coloured plates of the appearance of the tongue will be found useful, as an early and characteristic sign of psilosis is the alteration of this organ.

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**A Manual of Surgery.** By WILLIAM ROSE, M.B., and ALBERT CARLESS. Pp. 1162. London: Baillière, Tindall and Cox. 1898.

We have reviewed this book with much pleasure. It is an excellent work, of the type of small condensed surgical books now prevalent. The descriptions of surgical diseases and operations are well up to date and leave little room for criticism, which would be invidious upon a good book by experienced surgeons. Although we question the propriety of the regular administration of surgical knowledge in concentrated form, this

book may be safely recommended. The illustrations are largely borrowed from Tillmanns. The printing and paper are good, and there is evidence of very careful proof-reading.

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**Genito-Urinary Surgery and Venereal Diseases.** By J. WILLIAM WHITE, M.D., and EDWARD MARTIN, M.D. Pp. xix., 1061. Philadelphia: J. B. Lippincott Company. 1898.

The need is often felt of a book which gives more information than an ordinary text-book, and discusses more fully various methods of treatment. Such a need, so far as genito-urinary surgery and venereal diseases are concerned, will be supplied in this book. It is a work of much value, written by two well-known American surgeons. Indeed, Professor White is perhaps as well known in this country in connection with the treatment of hypertrophied prostate by castration as any American surgeon.

The anatomy of the various genito-urinary organs is given before their injuries and diseases are described; and this we are inclined to think a very useful and convenient arrangement. As an illustration of how fully the subjects are considered, we may refer to a table giving the differential diagnosis of the various parts of the urethra affected in gonorrhœa. The attempt to give the reader an idea of the appearance of gonorrhœal conjunctivitis by means of an uncoloured photograph, we must say, is a complete failure. The coloured photographs of venereal sores and syphilitic skin eruptions, also completely fail to represent the disease. Even coloured plates of venereal sores give a very imperfect idea of them. But the other illustrations in the book are very good, and some pictures of hypertrophied prostates from Watson are particularly fine.

No less than 240 pages are devoted to syphilis. We are glad to see syphilitic epididymitis mentioned, though it is not very clearly described; but attention is called to the similarity of this disease to tuberculous conditions, a subject seldom referred to in books. We are interested in the strong view expressed in favour of litholapaxy in boys, and the encouraging statistics which are given. The important subject of cystoscopy receives adequate consideration, and some very needful cautions are given as to the mistakes which may be made in the interpretation of the appearances presented. We notice a reproduction of a very clear skiagram of a stone in the kidney, and consider that the subject of renal surgery receives careful and comprehensive treatment. Diseases of the seminal vesicles, about which our knowledge is getting more precise, are here well described, and it is perhaps needless to say that we can hardly expect a better account of the treatment of prostatic hypertrophy by castration and vasectomy than we have in this volume, no doubt from the pen of Professor White. In the treatment of rupture of the urethra we are not told to cut down on the rupture if we can get a catheter into the bladder, nor is any mention

made of the fact that some eminent surgeons now recommend this proceeding in all cases in which the laceration is at all extensive, as a safeguard against urinary infiltration. But various views are as a rule very fully given, and in the pages devoted to the treatment of extroversion of the bladder the different methods are instructively discussed.

We strongly recommend the book as a modern guide to this branch of surgery.

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**Renal Growths.** By T. N. KELYNACK, M.D. Pp. xiii., 269. Edinburgh: Young J. Pentland. 1898.

It is just time that this book should appear. A vast amount of periodical literature has now accumulated on the subject, and Dr. Kelynack has given us a careful digest of it, together with his own observations, which, as he is pathologist to the Manchester Infirmary, are likely to be as numerous as those of most men. But the book is not by any means limited to the pathological aspect of the subject; though this naturally occupies the greater part of the book, the clinical aspect is fully considered, and even the operative treatment exhaustively discussed.

At the present time there is a good deal of confusion about the classification of renal tumours—so many varieties are now recognised—and the reader must not expect to gain a perfectly clear knowledge of the subject by the careful perusal of this work. The fact is, the subject has not got beyond the stage of early enquiry; tumours of different forms are gaining recognition as distinct varieties. But the knowledge on the subject which we at present possess is well and clearly given by Dr. Kelynack. The illustrations, both of the naked-eye appearance and of the histology of these renal growths, are remarkably good, and the bibliography is very fully given. We heartily congratulate Dr. Kelynack on the result of the labour which he has obviously bestowed on the production of this work.

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**A Handbook of Medical Climatology.** By S. EDWIN SOLLY, M.D. Pp. 470. Philadelphia: Lea Brothers & Co. 1897.

This book is intended for the use of three classes of persons: "the present generation of physicians who prescribe travel, the travelers themselves, and the rising generation of medical students should be taught to recognize the principles of medical climatology and its proper relation to general therapeutics." The author rightly summarises much of the mass of literature on the subject as a "desert of rubbish," in which commonly each writer claims for his own resort "the ability to cure all diseases, and the only invalids warned against coming are those in whom disease is far advanced." We may fairly class this book as one of the "bright oases of truth and reason" to which the author alludes. There are three sections: the first deals broadly with general principles of medical climatology,

the second treats of climate in relation to disease, and the third is devoted to special climates in selected resorts.

The question has been asked,[1] "What constitutes a good climate for the healthy?" The reply is, that one with constant moderate variations calls forth the energy of the different organs and functions, their power of adaptation and resistance, and keeps them in a working condition. Such are the climates of England all the year round: and they belong to the most health-giving in the world; for here we see the finest trees, the finest animals, the finest men—and they are most conducive to longevity, although not always the most agreeable or exhilarating. The climates for invalids are those with an abundant supply of pure air and water, the possibility of spending a great part of the day in the open air, good hygienic and dietetic arrangements, and the presence of a good local physician. Our own country—"Le pays ou il fait froid toujours, ou le soleil resemble à la lune et la lune à un fromage à la crême" (Dumas)—is not, however, the one where Dr. Solly derives his principal experience; and we naturally associate his name with the treatment of phthisis at the elevated health-resorts of Colorado.

As to the nature of the influence of altitude, he shows that the diminished barometric pressure is the principal factor; and after giving interesting information on the hæmatogenic effects of high altitude, more especially in consumptives, he quotes the experiments of Egger, made at Arosa in 1891, showing a marked increase of 16 per cent. in the number of the red blood cells. From an analysis of eight thousand cases he deduces the statement that there is a steady rise in the percentage of improvement as we go upwards: "That the majority of consumptives do better, other things being equal, the further they are removed from the sea, and that they do better in high than in low altitudes, wherever situated" (p. 137). "Le fait est donc pour nous indubitable, on ne devient pas phthisique à Quito" (p. 101). Gardiner's researches on the immunity found at high altitudes were commented on by us in the June number of 1898 (p. 127). We look upon the seventy-three pages on phthisis and climate as the most valuable part of the work. Dr. Solly has had a large experience and can speak with authority. His *résumé* of the indications and contra-indications in the climatic treatment of phthisis should be read by all on whom the responsibility rests of choosing a health-resort for those patients. Section III. gives an excellent outline of the different climates of all parts of the globe.

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**The Mineral Waters and Health Resorts of Europe.** By HERMANN WEBER, M.D., and F. PARKES WEBER, M.D. Pp. xiii., 524. London: Smith, Elder, & Co. 1898.

Known in its original issue as *The Spas and Mineral Waters of Europe*, this classical work has undergone much alteration and

[1] Clifford Allbutt's *System of Medicine*, 1896, vol. i. p. 284.

addition. The two entirely new chapters are amongst the most useful, inasmuch as they deal with the popular inland climatic health resorts, and the various special methods of treatment and sanatoria for phthisis. These resorts are classified in accordance with their elevation above sea level: those of high elevation being from 3500 feet and upwards, the medium class above 1500 and below 3500 feet, and those of slight elevation comprising places below 1500 feet. The localities of high elevation are described as "eminently stimulating and exhilarating and tonic. They promote the expansion of the chest and lungs, and the ventilation of the latter; they improve the appetite, the digestion, the nutrition and the oxygenation and quality of the blood. Under the diminished atmospheric pressure of high altitudes the number of red corpuscles in the blood rapidly increases, as also the percentage of hæmoglobin, though the latter does so more slowly." Accumulating evidence tends to show that we should not be content with any but the localities of high elevation if we wish to give a phthisical patient the chance of a radical cure, and if he is well enough and financially able to attempt it. After describing the dietetic cures and the various sanatoria for special treatment, the author adds the remark that "more sanatoria are undoubtedly needed, both institutions for the treatment of incipient and hopeful cases, and infirmaries for very advanced and very unfavourable cases, where patients who have no private means can be maintained, if necessary for the rest of their lives." Climatic treatment is usually expensive, as is the treatment of phthisis generally; and those who most need it are often those who can the least afford such luxuries as are to them necessities for the maintenance of life.

We are glad to observe that the authors do not encourage the practice of sending severe and advanced cases of diabetes to spas for treatment; they remark that "no complete and permanent cure of established diabetes is known to us from spa treatment"; and, further, "if the term 'diabetes' be accepted in this [Lauder Brunton's] sense, then one must say that only cases of 'glycosuria' are suited to spa treatment." We hold strongly to the belief that the ordinary glycosuria of middle life is most amenable to spa treatment; but that the advanced diabetic should remain at home, and carry on there such dietetic and other treatment as may be possible.

The volume is one which may safely be consulted with the expectation of finding in it sound advice grounded on good judgment and experience.

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**A Manual of General Pathology.** By WALTER SYDNEY LAZARUS-BARLOW, M.D. Pp. xi., 795. London: J. & A. Churchill. 1898.

Pathological anatomy is not touched in this book, which deals solely with experimental and general pathology. There

is no doubt that the English text-books on pathology have in the past confined themselves too exclusively to pathological anatomy, and the sections devoted to general pathology have been comparatively brief and unsatisfactory. They have, therefore, failed to keep pace with the advances made in experimental pathology during recent years, and thus to give a satisfactory account of a subject which has made great strides. To deal with the whole of pathology, general and anatomical, and at the same time to give an adequate account of those researches and conflicting views, which cannot be omitted without endangering the usefulness of the work, is however no longer possible in a text-book of anything like moderate dimensions, and there is therefore much to be said in favour of the author's contention that it is more convenient to consider general pathology in a separate treatise. Thus this volume comes naturally from the aspect from which it views pathology to occupy a place not hitherto satisfactorily filled by other text-books, and in this way performs a distinctly useful function, and seems likely to have a successful future before it. The manner in which the author has fulfilled his task deserves success, for the book is well written, and gives a very good account of all the most important advances in our knowledge of general pathology, and is brought thoroughly up to the level of the most recent researches. From the author's own investigations into the pathology of the blood-plasma, œdema, and absorption, it would be expected that the chapter on this difficult and at present much-debated subject would be a particularly good one, and there is an extremely able account of it, fully representative of present knowledge, and forming a distinctive feature of the work. The book is one to be recommended as a trustworthy one for students, and will also be found very valuable to practitioners who desire to keep their knowledge of general pathology not only up to date, but to extend it.

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**Beiträge zur Pathologie und pathologischen Anatomie des Centralnervensystems.** Von Dr. ARNOLD PICK. Pp. viii., 324. Berlin: S. Karger. 1898.

This book is made up of a number of essays on neurological subjects and reports of cases interesting either from the clinical or pathological side, and mostly from both. The cases, which are fully and clearly reported, are important as tending, many of them, to elucidate obscure or unsettled points in our knowledge of the pathology of the nervous system. In each instance there is a full critical commentary of the features of interest, and the references to the literature of the subject are unusually complete. In the first twelve papers, which, comprising about half the volume, deal with various kinds of aphasia, almost entirely sensory aphasia, will be found recorded many important cases,

and special mention may be made of the studies of subcortical sensory aphasia, of the significance in localisation of quadrant hemianopsia, and of Wernicke's conduction-aphasia. A series of five papers describe various arrests of formation and malformations of the spinal cord; these are very copiously and well illustrated. Three other chapters are devoted to a case of disease of the interolivary layer, and to the consideration of degenerations of the comma-shaped tract in the posterior columns of the spinal cord, and of von Bechterew's "Olivenbündel." Two cases of tumour of the corpus callosum lead to a discussion on the diagnosis of tumours in this situation, and there are also essays on the return of the knee-jerk in some cases of disease of the posterior columns, and on the clinical features of tabes dorsalis when it occurs in young subjects.

The numerous and well-executed figures of the pathological changes form quite a feature of the book, and add to its value, which largely consists in the number of original observations on cases which have been carefully studied, and which form an important contribution to neurological literature.

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**A Short Practice of Midwifery.** By HENRY JELLETT, M.D. Pp. xx., 323. London: J. & A. Churchill. 1897.

In this excellent compendium of the essentials of midwifery practice, the author commences with a well-written and precise chapter on aseptic principles and their practical application to midwifery. With reference to the principles laid down criticism is needless; the details concerning which some will disagree with the author are not important so long as the general principles underlying their application are correctly understood and carried out.

The chapter on abdominal palpation contains many very valuable hints on this important subject. The careful and precise explanation of manipulations gives no excuse for misunderstanding or mistake.

One or two practical points will meet with adverse criticism. In the treatment of accidental hemorrhage the author recommends plugging the vagina tightly; he brings good reason and authority for this method, which is not universally accepted as correct, but a view which is backed by the high authority of the Rotunda school must be received with a certain amount of deference. Had he added plugging the cervix to plugging the vagina, there would have been general agreement with him.

Dr. Jellett states that in the indications for the application of forceps, the head remaining four hours above the brim in the second stage is not of necessity an indication. We have known extensive sloughing follow less delay; with weak pains no doubt delay is harmless, but with strong pains danger is its early result. In the treatment of eclampsia he disapproves of the chloral and chloroform treatment, and prefers the hypodermic

administration of morphia: here again he is supported by his school, and although we should object to the adoption of any hard and fast rule in the treatment of these cases, this opinion, enforced as it is by favourable experience, should be accepted with due regard.

The tables at the end referring to the work of the Rotunda during several years are very interesting and well worth study.

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**A Text-Book of Diseases of Women.** By CHARLES B. PENROSE, M.D. Second Edition. Pp. 529. London: The Rebman Publishing Co. (Ltd.). Philadelphia: W. B. Saunders. 1898.

This is an excellent work which goes straight to the mark, untrammelled by needless anatomical, pathological, and histological details. The recommendation of one plan of treatment for each disease is useful for didactic purposes, but is not without its drawbacks when we consider the various clinical modifications of disease. For example, the operation for vesico-vaginal fistula described on pp. 400—402, though sufficient for the majority of cases, is inapplicable in many others in which the sloughing has been very extensive. In this connection, however, we are glad to see that the author condemns kolpokleisis. Dr. Penrose's style is clear and incisive, and the book may be taken as a trustworthy exposition of modern gynæcology.

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**Conservative Gynecology and Electro-Therapeutics.** By G. BETTON MASSEY, M.D. Third Edition. Pp. xv., 394. Philadelphia: The F. A. Davis Company. 1898.

So much new work has been added in this edition of Dr. Massey's book, that it may practically be considered a new work. The author sounds a useful note in stating that every uterine malformation is not a pathological entity requiring treatment; but we must insist that in some pelvic and abdominal cases, and these generally the most grave ones, there will be with the most "conservative" and experienced surgeons an absolute necessity of abdominal section for diagnosis. As a means of diagnosis, the rectal examination of virgins is very properly insisted upon, as it is quite possible to make a complete pelvic examination by this method.

The chapters on the use of electricity in gynæcology are very good, and will repay a careful study; but we cannot agree with the author in all his statements as to the benefits to be derived from this mode of treatment, nor do we consider it safe to employ electricity in certain diseases of the Fallopian tubes or in extra-uterine gestation. The benefit of electricity in fibroid tumours of the uterus is proved most completely, and the

various hints given as to the use of the battery, &c., will be of great service to those wishing to practise in this special department.

A striking feature of the volume is the excellence of its illustrations, which include half-tone reproductions of photographs of a professional model, whose services were called into requisition for the delineation of the typical methods of applying electric currents, and also for verifying the motor points of the nerves and muscles.

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**Guide to the Clinical Examination and Treatment of Sick Children.** By JOHN THOMSON, M.D. Pp. xvi., 336. Edinburgh: William F. Clay. 1898.

Dr. Thomson's work is a useful manual for students, but, as he says, it is only supplementary to larger works on the same subject. While he was engaged in the work it seems a pity a more complete guide to clinical examination of children was not produced, as at present some parts might well have been amplified with advantage, more particularly where any help is intended to be given on treatment. The illustrations are anything but a success, and we very much doubt whether anyone could gain much from Fig. 8 or 9, or several others. Diagnosis at sight may be a useful faculty to possess, but it is a dangerous one on which to rely. We hope in a future edition to see these photographs left out, or very materially improved.

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**Medical Diseases of Infancy and Childhood.** By DAWSON WILLIAMS, M.D. Pp. xvi., 634. London: Cassell and Company, Limited. 1898.

Of the many books on the diseases of children that have appeared lately, none strikes our fancy more than that by Dr. Dawson Williams. It is a handy volume, written in clear language and not over-burdened with statistics and tables on the composition of milk. As a practical treatise in a compact form, it is without a rival, and we can confidently recommend it to those who wish to improve their knowledge on this too often neglected subject. It will not of course compare with the larger volumes that come to us across the Atlantic, but they are too large and diffuse for the ordinary reader. The illustrations are few but excellent, being mostly reproductions of photographs. The only fault we have to find is, the small amount of space given to the treatment of skin diseases. They form a large part of the cases we see in the out-patient department of hospitals for children, and from the rapidity with which they improve and get well when the proper methods of dressing are impressed on the parents, we conclude that a little more knowledge on the part of the practitioner in the poorer parts of our towns might be of use. It is, however, one thing to write and instruct, and another to learn and apply.

**Tests and Studies of the Ocular Muscles.** By ERNEST E. MADDOX, M.D. Pp. xv., 427. Bristol: John Wright and Co. 1898.

Those who are familiar with the work of Dr. Maddox on ophthalmological prisms will anticipate in this volume a useful and interesting book; and they will not be disappointed. The problems dealt with are admittedly difficult and complex, but the author's clearness and precision render them comparatively simple; his happy and well-chosen expressions, his ingenious methods and luminous suggestions, convert a somewhat dry and tedious subject into a most interesting study.

We know of no book where so good a description of Tenon's capsule is given; but what will probably be found the most useful portions of the book are the chapters on ocular paralysis. These are so admirably clear, so carefully led up to, and so copiously illustrated, that if they are consulted a mistake in diagnosis is scarcely possible. Numerous clever contrivances and ingenious applications of already existing methods and apparatus are described. The author's "torsion calculator," which anyone can construct for himself, illustrates very prettily how, in certain cases of ocular paralysis, torsion of the false image is brought about; and new uses for the "tangent scale" are explained. The difficult and hitherto much neglected subject of "latent torsion" of the eyeball deserves special mention as indicating an advance in ophthalmology, and an attempt to discover a cause and possibly a remedy for certain cases of eye-strain.

Every chapter, every page almost, bears the stamp of the author's originality, and the diagrams and general get-up of the book leave nothing to be desired.

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**Nasal Obstruction.** By W. J. WALSHAM, M.B. Pp. viii., 256. London: Baillière, Tindall and Cox. 1898.

The author of this work has proceeded on somewhat unusual lines. He begins by working from the known conditions of the parts, such as redness, hardness, swelling, &c., to the unknown disease of which they are signs and symptoms, instead of first describing the disease and then discussing how it may be diagnosed from similar affections. He thus goes through all the diseases which give rise to nasal obstruction, and then finally he gives the treatment necessary for each variety in separate chapters at the end of the book. This method of teaching is frequently made use of in clinical lectures or in oral instruction during clinical practice, but it has many disadvantages when used in text-books. Thus it necessitates a great deal of repetition, it is wearying to the reader, and it separates the remarks on treatment from their natural position immediately after the diagnosis and symptoms and places them by themselves in another part of the book. To these objections with the author's

methods we would add unstinting praise for his matter. The descriptions of the conditions giving rise to nasal obstruction are most lucid and admirable. They are clearly defined and well differentiated. The treatment advised is eminently cautious and conservative, and does not partake of that meddlesomeness so common in the present day. All "spoke-shaving" of turbinal bodies is deprecated, and we do not find any mention of that bogey "necrosing ethmoiditis." The author states that, although he has performed a large number of intra-nasal operations, he has never known them to be followed by any septic sequelæ. The most rigid precautions are always taken to work with absolutely aseptic instruments and hands, but the nose having been shown to be practically an aseptic cavity, he never employs antiseptics in the form of washes or douches before operating, and having taken care not to introduce any septic material from without, he leaves the cavity after the operation rigorously alone. When this is done, an aseptic blood-clot forms, and no better antiseptic dressing or preventive for the injured tissue can be found.

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**Lectures on the Theory and Practice of Vaccination.** By ROBERT CORY, M.D. Pp. 122. London: Baillière, Tindall and Cox. 1898.

This book contains the substance of the lectures which Dr. Cory periodically delivers to vaccination students. The opening chapter is devoted to the discussion of the necessity for compulsory vaccination; and then follow chapters on the histology of the vaccine and small-pox vesicles, the difference between a primary and secondary vaccination, the eruptions that occasionally follow vaccination, the practical details of vaccination, and the relation of cow-pox to small-pox. The coloured plates and numerous statistical tables give an additional value to a work which undoubtedly should prove of service to the student. Unfortunately the work was written before the final report of the Royal Commission on Vaccination was issued, and consequently no reference is made to those changes in both the medical and lay minds which have led to the recent modification of our vaccination law, and to the adoption of glycerinated lymph. Indeed we find no reference to the bacteriological researches of Pfeiffer, Copeman, and Klein in connection with vaccinia; nor is mention made of the storage of lymph with glycerine, with a view to eliminating extraneous organisms. We should have wished that greater emphasis was laid upon the necessity for rendering the skin aseptic, sterilising the instruments, and the after-treatment of the arm on aseptic principles.

Dr. Cory regards generalised vaccinia as due to wholesale auto-vaccination, and that this is sometimes the case there can be no doubt. At the same time the experiments of Straus,

Chambon, Ménard, and Chauveau all point to the fact that a genuine general infection may follow vaccination—this quite distinct from auto-inoculation. Dr. Cory's book may be found suitable for elementary teaching purposes, but it cannot be regarded as embodying modern ideas in respect to the theory and practice of vaccination; and there is no excuse for the absence of an index.

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**Elements of Histology.** By E. KLEIN, M.D., F.R.S., and J. S. EDKINS, M.B. Revised Edition. Pp. xii., 500. London: Cassell and Company, Limited. 1898.—Although it is not so stated on the title-page, this is the third edition of this useful manual, and between its first appearance in 1883 and the present issue there have been ten reprints. It is quite modern; for many additions have been made, especially in the sections treating of the cell and the nervous system. The improved methods of staining introduced by Golgi and others have made it necessary to introduce numerous fresh illustrations and diagrams. Only eighteen pages are given to the cell, but a great deal of new matter has been introduced, and the chapter may be taken as a fair *résumé* of the present knowledge of the subject. The somewhat puzzling terms that have been manufactured of late to express the different parts of the cell-structure and the changes in the nucleus, etc., are clearly used; but there is some redundancy—*e.g.* mitoma, intra-nuclear network, and chromosomes, all meaning the same. A noticeable feature is the photo-micrographs which appear in this edition. Some are useful; but many are very poor, especially those on pages 57, 205, 301, and 332. These are so indistinct as to be almost worthless. On the other hand, most of the illustrations and diagrams are decidedly good, and the account of the histology of the various organs is concise and clear; so that an average student can gain an excellent knowledge of minute structure from this work, which is sure to be popular.

**Practical Organic Chemistry.** By S. RIDEAL, D.Sc. Second Edition. Pp. x., 172. London: H. K. Lewis. 1898.—The second edition of this text-book has afforded the author an opportunity of including some additions to the lists of substances, a practical acquaintance with which is required of candidates for certain of the higher examinations. The properties and reactions of the more common organic bodies are concisely and accurately described, and the information is conveyed in a manner which will render it easily assimilable by those to whom it is especially addressed.

**Notes on Malaria in connection with Meteorological Conditions at Sierra Leone.** By Surgeon-Major E. M. WILSON. Second Edition. Pp. 16. London: H. K. Lewis. 1898.—We reviewed the first edition of this booklet some time ago, and pointed out the salient features of the opinions of the author. We have

not yet heard that the Government have made the alteration in diet Major Wilson recommends. But then permanent officials move slowly.

**Materia Medica, Pharmacy, Pharmacology, and Therapeutics.** By W. HALE WHITE, M.D. Third Edition. Pp. xvi., 621. London: J. & A. Churchill. 1898.—Except to record that this third edition of Dr. Hale White's work is fully brought up to date and includes all the changes in the recent edition of the *British Pharmacopœia*, it is not necessary to enter into any detailed criticism upon it. It remains, as before, admirably concise, containing all that it is absolutely essential for a student to know about pharmacology and the therapeutical uses of drugs. Although treating mainly of substances included in the *British Pharmacopœia*, the book is not exclusively restricted thereto, for many useful but non-official remedies, such as exalgine, are noticed in their proper places. We heartily commend the work.

**Notes on Pharmacy and Dispensing for Nurses.** By C. J. S. THOMPSON. Pp. 101. London: The Scientific Press, Limited. 1898.—Nurses will find this small work of use in learning how to dispense medicines. The author has put what he wants them to learn clearly and as briefly as possible, but he has sometimes rather outstepped the range of what a dispenser has to do.

**Baby Feeding.** By A Doctor. Pp. 62. Bristol: John Wright & Co. 1898.—The information given by the author, who modestly appears as M.B., B.Ch. (Univ. Dub.), is of a thoroughly sound nature, clearly and forcibly expressed. We are afraid, however, there are a few "nots" in Chapter VI. that are seldom attended to, and, moreover, never will be as long as the world goes round. For all that, the advice is good and cannot be too often repeated. Drops of water wear the rock, and we wish every success to the author's drops on the rocks of superstition and ignorance.

**Health Loss and Gain.** No. 1. By M. A. CHREIMAN. Pp. 226. London: The Rebman Publishing Company, Limited. 1898.—The author proposes "that there should be instituted, as a custom, a system of periodical examination, to which all persons should submit themselves, and to which they should submit their children." We fear that his method would be an excellent means for the multiplication of the nervous hypochondriac, and we hold that if apparent health is working duly without friction it is best to leave it so. The writer has views on many things, and the volume is well worthy of perusal; but one cannot fail to observe that there is an absence of the medical instinct usually associated with the medical mind.

**Dwelling Houses: their Sanitary Construction and Arrangements.** By W. H. CORFIELD, M.D. Fourth Edition. Pp. xiv., 125. London: H. K. Lewis. 1898.—This edition has been

carefully revised throughout by the author, and within its scope forms a good guide for the lay reader.

**Association Française de Chirurgie. Onzième Congrès. Procès-verbaux, Mémoires et Discussions.** Paris: Félix Alcan. 1897.—A large field is covered in these transactions; but especial attention should be directed to the papers and discussions on contusions of the abdomen, and the operative treatment of cancer of the rectum. The book is suitably illustrated in various parts, and reflects the highest credit on the work of French surgeons.

**Recherches cliniques et thérapeutiques sur l'Épilepsie, l'Hystérie, et l'Idiotie.** Vol. XVIII. Paris: Félix Alcan. 1898.—In the Bicêtre Asylum, of which this is the annual report there is excellent work being done. Records of many interesting cases of idiocy are given, amongst which are several of importance from a pathological point of view, and of great interest as regards the lesions of the brain. Dr. Bourneville finds in one case a further confirmation of his views as to false and true porencephaly, and it would certainly be well if the present vague use of this term was given up for a more restricted signification. A case in which there were lesions of both frontal lobes is also worthy of study. We must call especial attention to the beautiful reproductions of photographs of the brains of the most important cases, which are given in a series of fine plates, eighteen in number. We regard this volume as an important contribution to the pathology of the brain conditions underlying some forms of idiocy, and the cases recorded in it are worthy of careful perusal.

**King's College Hospital Reports.** Vol. IV. London: Adlard and Son. 1898.—This volume contains a continuation of John Curnow's historical sketch, and has an interesting account of the enthusiasm and the work of Robert Bentley Todd. The original papers are not numerous: Dr. Nestor Tirard gives an interesting account of albuminuria in children; Mr. Albert Carless advocates early operation in cases of appendicitis; Dr. Arthur Whitfield, writing on the diagnosis and management of syphilis, advocates the view "that iodide may be used to help in the improvement of some symptoms, but on mercury must we rely wherewith to combat the disease"; Dr. Raymond Crawfurd prefers a combination of belladonna and nux vomica to various barbarities which have been reputed to be of use for the enuresis of childhood; Dr. Hugh Playfair considers it to be absolutely essential to combine local application with constitutional treatment for most cases of leucorrhœa; and Dr. J. Curtis Webb gives some interesting reminiscences of gynæcology in Berlin. The statistical reports and records of cases of interest follow, and the account of what old King's men are doing is of especial interest to those whose names are found there.

**Saint Bartholomew's Hospital Reports.** Vol. XXXIII. London: Smith, Elder, & Co. 1898.—The volume of reports begins this year, as it has unfortunately done rather often of late, with an obituary notice of a member of the hospital staff. In the present volume Dr. Church gives a very interesting account of the life of Dr. James Andrew, who retired from work at the hospital some few years ago, and died in April, 1898. Such accounts are of sad but special interest to all old Bartholomew's students, and the graphic description of Dr. Andrew in his ward work is one which will recall many scenes connected with their study of clinical medicine. There are many papers of great value in the reports this year. As we might expect, many record interesting cases which have been in the hospital, and both the clinical and pathological sides of the work have yielded important results. There is perhaps no record of clinical work which gives so accurate an account of the difficulties and mistakes in diagnosis, and the failures in treatment, as the report of all cases of interest occurring in a large hospital during the year, and these we find admirably given in this volume. Instead of the publication of the successful cases only, to which we are all tempted, we have here many examples of failure both in diagnosis and treatment, which are really often more instructive than the successful ones.

**The American Year-Book of Medicine and Surgery.** London: The Rebman Publishing Co. (Ltd.). Philadelphia: W. B. Saunders. 1899.—*The American Year-Book*, a digest collected and arranged by a large staff under the general editorial charge of Dr. George M. Gould, has now become an established perennial in its fourth year. The volume covers a large scope, including all the special branches of medicine and surgery, pharmacology, anatomy, physiology, legal medicine, public hygiene and preventive medicine. Sixteen of the twenty-eight contributors are well-known specialists and teachers of Philadelphia; New York city claims four, Chicago three, Cleveland two; and Baltimore, Boston, and Montreal can each claim one. The staff may well be complimented on "that expertness of intelligence in gleaning and ripeness of judgment in deciding as to values which can only be gained by experience and knowledge." The book may be opened at any page, and the reader will find something interesting, novel, and well presented in excellent type. The omission of the name of Dr. William Pepper from the list of contributors is mentioned by the editor, and the whole world of medicine is the poorer by the death of that distinguished man.

**Annual and Analytical Cyclopædia of Practical Medicine.** Vol. II. The F. A. Davis Company. 1899.—The second volume of this great work has now arrived. It commences with bromide of ethyl and concludes with diphtheria. The volume contains exceptionally valuable articles on a number of exacting subjects, viz.: "Cerebral Hæmorrhage," by Dr. William Browning,

of Brooklyn; "Cirrhosis of the Liver," by Professor Adami, of Montreal; "Cholera," by Professor Rubino, of Naples; "Cholelithiasis," by Professor Graham, of Toronto; "Diabetes," by Professor Lépine, of Lyons; "Diphtheria," by Drs. Northrup and Bovaird, of New York; "Constipation," by Professor Nathan S. Davis, of Chicago; "Dilatation of the Heart," by Dr. Vickery, of Boston. These and many other articles deserve the reader's special attention and study. The volume is beyond all praise or criticism, and Dr. Sajous deserves the hearty thanks of all engaged in the practice of medicine.

**The Medical Annual.** Bristol: John Wright & Co. 1899.—The amount of useful information given to the busy man in this volume is remarkable. Most of the contributors to it are not mere abstractors, but are experienced in various branches of medicine and surgery, and so are able to select from and to criticise the great mass of newly-published work which they lay under contribution. The book is, as has hitherto been the case, well printed and illustrated, and we cordially recommend it to our readers. We think that many provincial societies deserve a place in the list of "Medical and Scientific Societies."

**The Edinburgh Medical Journal.** New Series, Vol. IV. Edinburgh: Young J. Pentland. 1898.—The half-yearly volume contains a collection of excellent papers worthy of careful study by those who have not received the monthly parts. Many of the papers read at, and a general summary of the proceedings of, the British Medical Association at Edinburgh are included. Dr. Finlayson has an interesting paper on "Medical Bibliography and Medical Education," in which he advocates the more general teaching of medicine by clinical work, and cites the instance of Johns Hopkins University, which has abolished systematic lectures on medicine. The reviews of British and foreign literature, and the reports on recent advances in medical science, are done with much care and by authorities in the various departments. We congratulate the editor on the result of his efforts.

*Ἰατρικὴ Πρόοδος. La Grèce Médicale.* Syra: Impr. Renieri Brindesi.—Medical journalism in Greece has had apparently rather a chequered career, one or two journals which we have seen in past years being now extinct. *Ἰατρικὴ Πρόοδος* is, however, in the fourth year of its existence, and has hitherto appeared in the Greek language only. In order, however, that the active advance of medicine in Greece may become more generally known among other nations, with the monthly issue of the Greek journal there is now published an appendix in French, *La Grèce Médicale.* Of both sections we desire to speak with much commendation; the subject-matter and occasional illustrations are thoroughly praiseworthy, and we wish this addition to our exchange-list long life, and its editor, Dr. Foustanos, a full measure of success.

**Archives provinciales de Médecine.** Paris: Institut international de Bibliographie scientifique.—We are glad to welcome on our exchange-list this new monthly journal, which, following somewhat on the lines of the *Archives provinciales de Chirurgie*, has started a career in the direction of decentralisation in medicine. With a large staff of supporters scattered throughout the principal cities of France, it may be expected to have a very successful and useful course, and we wish Dr. Marcel Baudouin, the editor, all possible recognition of this new effort which he is making, in addition to those many others which have so considerably benefited the profession.

**The British Food Journal.** Vol. I., No. 1. January, 1899. London: Baillière, Tindall & Cox.—This is one of the most remarkable—we had almost said impudent—pseudo-scientific publications that has ever appeared in print. The responsibility for its existence rests upon the shoulders of an "editorial staff" including some names which it is to be hoped decorate the cover without the knowledge of their owners. After drawing attention to certain excellent recommendations by the Censors of the Institute of Chemistry on the question of unprofessional conduct, with special reference to advertising and the issue of trade puffs, the "editorial staff" proceed to traverse the more important ones by offering themselves to the manufacturing world as testimonial-mongers on the co-operative system, on the principle, it is to be supposed, of the unkickability of the corporate body. The fact that this proposal is enshrined in a quantity of doubtful information collected apparently from the columns of the daily papers does not alter its character; and it is much to be desired that the Institute may use its influence to check a movement that can only tend to discredit one of the youngest, but not least useful, of the professions.

**The Philadelphia Monthly Medical Journal.**—Dr. Gould's excellent weekly journal is now to have a monthly supplement, which is to consist of original contributions only. For very good reasons no doubt, No. 3 is the first to be issued. It contains the prize essays in connection with the weekly journal. The first prize in the department of medicine was awarded to a paper by Dr. Henry Wald Bettman, of Cincinnati. It describes the shape, position and displacements of the stomach, and gives an excellent account of the diagnosis, prophylaxis, and treatment of gastroptosis and gastro-enteroptosis. A very complete bibliography is appended, and an analysis of the most important recent papers on the subject: on the authority of Meinert[1] we are informed that "every dress fastened about the waist worn by a girl before her fifteenth year leads inevitably to gastroptosis"; there is, therefore, no need to wonder why it is that 90 per cent. of adult women have gastroptosis, whereas it is present in only about 5 per cent. of men. The other papers

[1] *Centralbl. f. innere Med.*, 1896, xvii. 297, 321.

are worthy of careful consideration, and this new departure of Dr. Gould's deserves to be heartily supported.

**The Polyclinic.** Vol. I. No 1. May, 1899. London: H. K. Lewis.—Our Exchange-list has received the addition of this Journal of the new Medical Graduates' College. Sir W. H. Broadbent writes on "The Necessity for a Medical Graduates' College;" Mr. Jonathan Hutchinson gives "Some Account of the Formation and Aims of the College;" and Dr. Wm. Miller Ord, in considering "The Medical Practitioner as a Student," says: "The scheme of Post-Graduation Teaching now established will be found to offer large opportunities of self-improvement along many lines of work. The whole plan is framed to insure practical instruction in all departments. Those who will occupy the position of teachers, and those who come for instruction, will work side by side assuredly to the benefit of both. . . . The proverb 'Docendo discimus' is as true as ever." The list of officers and Council is one which will command success.

## Notes on Preparations for the Sick.

**Diastol.**—THE STANDARD MALT EXTRACT CO. LIMITED, London.—The manufacture of this digestive is carried on at Clayton-le-Moors, Lancashire, by a special process, which gives excellent results. The diastasic power is high, and its use in many forms of dyspepsia gives good results, enabling cases of phthisis and other diseases of mal-nutrition to assimilate farinaceous foods in greater quantity than without it. In many cases of chronic dyspepsia we have found this preparation to be of real service. "If the starchy elements of the food were eliminated from the diet in a case of amyldyspepsia the alimentary troubles would soon cease," and so would the normal nutrition of the tissues unless the patient cared to run the greater risk of uric acid and urate poisoning. We think that the digestion, *even if artificial*, of the starchy foods is better than their elimination from the dietary.

**Varalettes: Citrate of Lithia; Citrate of Piperazine; Glycerophosphate of Lime; Urotropine; Potass. Citrate, Lithia Citrate; Soda Salicylate, Antipyrine, Caffeine pure; Vichy Salts.**—ALFRED BISHOP & SONS LTD., London.—These are the newer forms of Bishop's well-known preparations. The powder is compressed into what are called varalettes, which are said to have all the advantages of the tabloid combined with a greater solubility.

**Meta-Cresol-Anytol.**—GUSTAV HERMANNI, Jr., London.—This is specially prepared for the local treatment of diphtheria. It may be used as a three per cent. aqueous solution, either by

inhalation or spray: the maker claims that it is non-irritating, is fatal to the cocci, and has a neutralising alterant action on the diphtheria toxin.

**Public Vaccinator's Bag.**—FERRIS & Co., Bristol.—In country districts it would be found convenient to carry such an assortment as is contained in this very complete and portable bag.

For use in towns the pocket case included in the bag will generally be found sufficient. To those who over a long number of years have vaccinated thousands of children with excellent results these cumbrous paraphernalia seem quite unnecessary. Their introduction very much resembles the employment of a steam-hammer for cracking a walnut. The people who are charged with the administration of vaccination laws and practice are very nearly succeeding in making the whole thing ridiculous. In the *British Medical Journal* for February 25th there is an excellent illustrated satire on the new methods.

## MEETINGS OF SOCIETIES.

### Bristol Medico-Chirurgical Society.

*March 8th*, 1899.

Dr. R. ROXBURGH, President, in the Chair.

Dr. H. WALDO showed (1) a boy, aged 11 years, with Adenoma sebaceum of the face, which had existed for about a year. He said that this disease was characterised by the appearance of neoplasms papular in character, of congenital origin, but appearing at or before

puberty. There is a distinct outline to each lesion, and coalescence is unusual. A large proportion of the subjects are epileptics or imbeciles, and it was at one time supposed that bromides produced the eruption. Adenoid changes are found in the sebaceous glands. The papillary vessels are conspicuous, and there is an increase in the connective tissue. There is, in fact, a replacement of large numbers of hair-follicles and sebaceous glands by fibrous tissue, of which the little tumours are largely composed. There is extensive interpapillary hypertrophy. The lesions may be flat-topped, others rounded, convex or acuminate, while some may be warty-looking, and may be pedunculated, though the customary papule is sessile. Involution may occur, but the tendency is to persistence, the lesions recurring in spite of removal and even *in situ*. (2) A young woman with tuberculosis of the skin. The patient received a wound of the right leg six months ago. She says that shortly after this a rash extended all over her. When first seen there was a broad streak of lupus erythematosus extending down the left arm and forearm, with a circular patch the size of a half-crown on the right forearm, and also a well-marked bat's wing arrangement on the face and nose, with a slight implication of the left ear; in fact, the disease was becoming generalised. This condition had been present for four months. She thought she had lost flesh. There was no cough. He prescribed an emollient and slightly-astringent lotion during the day, and an ointment of sulphur and carbolic acid to be rubbed in at night. She was to take cod-liver oil and quinine; to keep her bedroom window well open at night, and to be in the open air as much as possible in the day. The patient was now nearly well.

Dr. J. E. SHAW showed (1) a case of acute anterior poliomyelitis, which had existed six months, involving the whole of the muscles of both legs, including the glutei; the case is remarkable in that not the slightest degree of recovery has taken place. (2) A case of spastic diplegia which began to develop at 9 months of age. Patient now has the usual cross-kneed progression, but the legs are permanently bent upon the thighs; the feet are long, flat, not in a position of talipes equinus, and are everted. (3) Two cases of pseudo-hypertrophic muscular paralysis occurring in brothers. The younger, aged 6, exhibits the usual phenomena of an early stage, being able to stand and walk alone and rise from the floor unaided; the knee-jerk is present. The elder, aged 12, cannot stand or walk alone, and cannot rise from the ground beyond getting on to his knees. He stands, when sustained artificially, upon his toes and toe-balls, the heel never coming down upon the ground owing to the contraction of the calf muscles maintaining the feet in the position of talipes equinus. The calf muscles are not very large, but are very hard; the knee-jerk is absent on both sides.

Dr. MICHELL CLARKE showed (1) a case of syringomyelia in a young man of 17. The illness began in July, 1898, with weakness and wasting of the muscles of the left hand. There had been no pain throughout. The symptoms present now are: atrophy of the small muscles of the left hand and of extensors of the left forearm, with paralysis of the left upper extremity; wasting to a less degree of the left deltoid, biceps, pectoralis major, and of the small muscles of the right hand; loss of sensation to pain, and to heat and cold, but not to touch, over left arm and left side of chest. There were also spastic rigidity of the legs, double ankle-clonus, left rectus-clonus, and exaggerated right knee-jerk. (2) A case of disseminated sclerosis in a sailor, aged 39, who had not had syphilis, and had enjoyed very good health. He attributed his illness to privation and exposure.

There were well-marked intention tremor of both arms, most in the right; scanning speech, exaggerated knee-jerks, weakness of arms and legs, attacks of vertigo, with defect of associated movement of the eyeballs to the left. (3) A case of progressive muscular atrophy with absent knee-jerks, and remarkably extensive distribution of the muscular atrophy for the presumably early stage of the disease.—Dr. WALDO asked Dr. Clarke if the retinæ had been examined ophthalmoscopically, as he considered that atrophy of the papilla was very often found in cases of disseminated sclerosis, and might assist in the diagnosis of an obscure case.—Dr. CLARKE, in reply, said that the optic discs were pale.

Dr. E. C. WILLIAMS showed a case of hemiplegia, with wasting of the muscles of the leg, of six years' duration in a child aged 11 years. The onset was sudden—pain over the left temporal region, followed by a convulsion. After the convulsion, there was loss of speech and paralysis of right side of face, right arm, and right leg. She gradually recovered from the aphasia and facial paralysis in about fourteen months. There was no history of rheumatism, chorea, or any infectious disease. She is of slow intellect and very forgetful. On admission to the Children's Hospital, under Dr. Lees, her right arm was in a spastic condition—elbow and wrist more or less flexed, fingers flexed or extended and rigid, movements being slow and usually tremulous. The right arm measures more than the left, the increase being probably due to the constant choreiform movements. Electrical reactions, normal; heart and lungs, healthy. Right leg measures 1 inch less than left. There is pes cavus. Some of the leg muscles give the reaction of degeneration; knee-jerks, glib. The seat of the lesion appears to be in the upper motor segment, for the following reasons: 1, The lesion is a hemiplegia; 2, aphasia and facial paralysis at onset; 3, no reaction of degeneration in upper limb; 4, reflexes present. The lesion is double; *i.e.*, there is an anterior poliomyelitis as well as an upper segment lesion (polio-encephalitis). It would appear the two lesions are the result of the same poison, which more commonly affects the anterior horns, but also affects the ganglion cells of the cortex. The disease is often epidemic, many cases being reported in the *Journal of the American Medical Association*, xxvi., 1896, in which the characteristic symptom was paralysis in young children. It was attributed to insanitary surroundings. An elder brother of this child had a similar attack seventeen years ago, but made a fair recovery.

Mr. MUNRO SMITH showed a boy on whom erasion of the knee-joint had been performed, a year ago, for extensive disease of the synovial membrane and cartilage. The bone was slightly affected. Two operations were performed before the disease was eradicated. The boy can now walk easily and well, and there is very slight shortening.

Mr. C. A. MORTON showed a woman, aged 59, from whom, in November last, he had excised the cæcum for a carcinomatous growth. The ileum was joined to the ascending colon with a Murphy button. The growth had been so movable that it simulated movable kidney. Not only could it be pushed into the loin, but also as far inwards as the umbilicus. The patient had gained 2 stone in weight since the operation.—Mr. ROGER WILLIAMS said cancer of cæcum was such a comparatively rare disease that but few examples of its successful removal have been reported. He could at that moment recall only two cases in which an operation of this kind had been done. One was by Homans, in which he successfully excised a sarcoma of the cæcum

from a girl of 5. In another case Abbe excised the cæcum and several feet of intestine from a youth of 16, uniting the divided ends of gut by a Murphy button. The patient died shortly after operation. It was interesting that in Mr. Morton's case there were no symptoms of obstruction, as this had been noted in several cases of cæcal cancer, wherein it differed so markedly from other cancers of large intestine. Of 100 consecutive cases of cancer of the large intestine, Mr. Williams found that ·5 per cent. were cæcal and ·5 per cent. of ileo-cæcal valve, whereas Fagge found 4 per cent. were cæcal.—Dr. LACY FIRTH remarked that one of the difficulties in the operation of removal of the cæcum was due to the difference in size of the two portions of bowel which had to be united. He had heard of one successful case, in which the end of the colon was partially closed by sutures and the small intestine then fixed to the portion remaining open by means of a Murphy button. He had on one occasion removed the cæcum for malignant disease, and had attempted to overcome the difficulty mentioned by closing up the end of the colon and then fixing the end of the ileum to its side with a Murphy button, but the patient unfortunately died on the seventh day. He asked if Mr. Morton had found any difficulty in his case in approximating the ileum to the colon by reason of the difference in calibre.—In reply to Mr. Roger Williams and Dr. Firth, Mr. MORTON said he had not yet had time to look up the literature of the subject, but would refer to it when he published the case. There was considerable difficulty in getting the cut edge of the ascending colon into the grip of the button, which was the one used for the junction of small intestine.

Mr. T. CARWARDINE showed two patients after excision of the rectum for malignant disease by a method which he had devised and described in the *British Medical Journal*, 1898. Each patient has a partially renewed and bifid coccyx and intact sphincter, and perfect control over fæces, and the case operated on six months ago has control of flatus also. Defæcation is performed voluntarily once or twice a day, and rectal sense is perfect.—Mr. C. A. MORTON asked if Mr. Carwardine left a segment of the lower end of the rectum in his two operations. He thought that if the growth extended far up the rectum the peritoneum must of necessity be opened in the removal of the growth, as in the ordinary Kraske's operation.—Mr. CARWARDINE, in reply, said the amount of anal mucous membrane left may vary with the case. The facility with which the peritoneum can be deflected from the presacral glands and tissue in this method of operation avoids the necessity, as in Kraske's operation, of frequently opening the peritoneum.

Dr. E. H. E. STACK showed a case of precocious menstruation. The girl was 5½ years, and mentally a little deficient. Periods began at 18 months, and have been nearly regular ever since, lasting three days and requiring seven diapers. The breasts began to develop about the same time, and have progressed since; now the diameter is 3 inches, and depth at nipple 1½ inches. The pelvis has a grown-up appearance, and, comparing its measurements with about twenty others of ages from 5 upwards, it conforms to the average of those of 12 years. The external genitals are not much abnormally developed; there is a little downy hair over them about ¼ inch long. She has been twice seen menstruating, and blood had the appearance of a normal period. There have been thirty to forty cases reported, and about twenty of these seem genuine and do not include cases beginning at 7 or 8 years or the bleeding once of new-born babes. They are very much alike. Average beginning was 2 years; most, but not all, had distinct growth of hair on pubes, but not in axilla. All had well-developed breasts;

most were otherwise normal children; some seemed older than their years. Longest record is a child of 11, who began at 16 months. Only one case of very early puberty in a boy was found. No cause appears in the way of family history, climate, etc.—Dr. AUST LAWRENCE said that he would have liked to have had some information on the condition of the pelvic viscera as ascertained under chloroform or by rectal examination.—Mr. ROGER WILLIAMS regarded the condition as not so rare as was generally believed, and he had collected notes of over fifty cases. Nothing was more remarkable in the history of the development of the body than the great punctuality with which the different developmental events came off, although in exceptional cases a wide range of variability in this respect was not incompatible with health. Developmental anomalies with regard to time were quite as interesting and important as structural anomalies; and they were met with in respect to dentition and other conditions, besides sexual development. He thought many cases of this kind might be ascribed to reversion. Very few animals arrived at sexual maturity at such a late age as man; and among savages—where the waste of life was great—sexual maturity and reproduction ensued at much earlier periods than in modern communities. In this connection it was interesting to note that among the Hindoos—who were a branch of the same stock as ourselves—sexual maturity usually set in at an earlier age than with us, girls often attaining puberty at 8 years or even earlier. Premature sexual development was met with in boys as well as in girls, although most of the recorded cases were of the female sex. It might supervene at any time from birth to the normal age of puberty. A curious feature in many cases was that this precocity only manifested itself in respect to some of the constituent phenomena that go to make up sexual maturity. Thus in some cases the only evidence of it was mammary overgrowth; in others, menstruation; in others, undue development of the genitalia, etc. In most cases, however, the *ensemble* of the phenomena of sexual maturity was affected. Mr. Williams thought it might be inferred from the foregoing that the various phenomena which together constitute sexual maturity had been gradually integrated and co-ordinated, rather than that they had suddenly sprung into existence as a physiological unity. The internal sexual organs were often affected, as well as the external ones; for in necropsies on cases of this kind maturing Graafian follicles, corpora lutea, and recent ovarian cicatrices had been found with the pubescent uterus, ovaries, tubes, and pelvis; in short, there could be no doubt but that in these cases we had to do really with puberty. In support of this, he referred to cases of early pregnancy, at from 8¾ to 12 years, these young mothers having manifested signs of sexual precocity from earliest infancy. In one case of this kind the mother, aged 12, was impregnated by a boy of 14, and in due course she was delivered of a healthy child. Many cases of premature sexual development had been met with in children having intra-abdominal tumours, such as ovarian cystomata, sarcomata, etc., and adrenal tumours. In these cases the condition seemed to be caused, and the local congestion determined, by the presence of the tumour. In this connection it was interesting to recall the cases in which lactation had been excited—in young children and others—by repeated suction of the nipples, etc. Thus it seemed that sexual precocity might result from extrinsic as well as from intrinsic causes. —Dr. C. ELLIOTT stated that all cases of so-called premature menstruation should be carefully examined, as the discharge of blood from the vagina was not always from the uterus. Some years ago a young girl was brought to the Children's Hospital who had been seen by more than one medical man, and the mother was told by them that it was

a case of premature menstruation. Not being satisfied with this diagnosis, he admitted the child into the Hospital and had the bladder examined. A hairpin was found with one point protruding through the urethra, and a phosphatic calculus had formed around it. His colleague, Mr. Norton, broke down the calculus, and removed the hairpin with some difficulty.

Dr. F. H. EDGEWORTH read a paper on the treatment of bronchitis, which will appear in a subsequent number of this *Journal*.

Mr. ARTHUR PRICHARD read notes on a case of hæmatometra in which, by strict antisepticism and slow draining of the tumour through the imperforate hymen, a cure resulted. The case was that of a girl aged 18, who first noticed a swelling in the lower part of the abdomen seven months before coming under observation. There was no pain at regular intervals. She had never menstruated. The vagina was occluded by a tense membrane, slightly bulging, to which an impulse could be communicated by pressure on the abdominal swelling. It was drained into sterilised wool pads by a small tube, and the catheter used when required. In three days the tumour, which before reached to 1 inch above the umbilicus, was almost gone. The discharge lasted for fifteen days. The vagina was subsequently dilated. The upper part was capacious, and had constituted part of the abdominal tumour. The os uteri would admit the tip of one's forefinger.—Dr. AUST LAWRENCE mentioned three cases of hæmatometra which he had seen. 1. Imperforate hymen, vagina and uterus distended, with retained menstrual blood. Treated by slowly draining through cannula and tubing into a bottle containing carbolic lotion. Perfect success. 2. Occluded os uteri, the result of *post-partum* sloughing of cervix uteri, the retained fluid caused uterine enlargement equal to a six months' pregnancy. Treated by slow draining through an opening made in position of normal os uteri, as case 1. Complete success. 3. Imperforate os uteri in one half of a bifid uterus, the other half menstruating normally. Treated as No. 2, but patient died from septic peritonitis, due to escape of menstrual blood into the abdomen, owing to rupture of the adherent and distended tube on that side. The symptoms of this were very indefinite.

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*April 12th*, 1899.

Dr. J. E. SHAW in the Chair.

The CHAIRMAN showed a patient with peroneal type of muscular atrophy, which will be described in a later number of this *Journal*. —In connection with this case Dr. MICHELL CLARKE showed photographs of the hands of a patient, aged 10, under his care eight or nine years ago. There was wasting of the small muscles of the hands and of the muscles of the forearms, and the fingers were contracted in flexion. The disease came on after one of the acute specific fevers. The wasting appeared to be stationary, and the patient after attending at the Hospital for some time was lost sight of. Her case was one of neuritic atrophy.—Dr. E. J. CAVE mentioned the interesting pathological question raised by the fact that what appeared to be a primarily neuritic affection should be liable to occur in members of the same family, especially in regard to the part played by measles in the etiology of the condition. Such family groups were more familiar in primary muscular or spinal affections.

Dr. H. WALDO showed a patient with tubercular peritonitis treated by operation. He was brought to the Infirmary with a tubercular temperature, a tender and swollen abdomen, depending in the first instance upon tympanites and shortly afterwards on ascites. He was acutely ill, and Dr. Waldo thought an abdominal incision would give him the best chance. The most satisfactory results from this treatment occur in the ascitic variety.—Mr. W. H. HARSANT said that when the boy came under his care he seemed so ill and hectic, and was so rapidly losing weight and strength, that it was obvious he would not recover unless something were done. A small incision was made and 4½ pints of fluid were evacuated. The peritoneal cavity was then freely washed out with sterilised water, and the wound closed without drainage. Recovery was rapid and most satisfactory; and though it was too early yet to speak of a cure, it seemed as if this boy would probably remain well. It had been laid down by some observers that a cure could not be said to be assured until five years had elapsed. The cases most favourable for operation were those occurring in young patients with an acute history and where there is a free exudation of fluid, and all these circumstances were combined in the present case.—Dr. WALTER SWAYNE stated that he himself, some years ago, suffered from an affection which was diagnosed as tubercular peritonitis, with symptoms of abdominal distension, general wasting, slight ascites, and for a short time some evening rise of temperature. He recovered without operation, and was pleased to hear Mr. Harsant's statement that after five years the patient might be considered safe.—Mr. C. A. MORTON alluded to three cases under his own care in which ascites from tubercular peritonitis had been present, operation had been postponed, and in all the cases recovery had taken place without. He thought that surgeons had brought forward theories which, as Dr. Waldo had stated, were most unsatisfactory explanations of the improvement after laparotomy, because they had failed to recognise the fact that probably a large number of the cases operated on would have recovered without. Hawkins[1] had shown that 59 out of 100 cases of tubercular peritonitis, treated in the wards of St. Thomas's Hospital, got well without operation. But he thought that when it was necessary to evacuate the fluid on account of the pressure which it exerted, it was far safer to do so by incision than by tapping. A short time ago he had seen a lady suffering from ascites from tubercular peritonitis who had a few hours before been tapped, and only fæces had escaped. The area tapped had been quite dull, no doubt because the adherent bowel was at the time empty of gas. He thought the chance of adhesion of bowel to the anterior abdominal wall was so great in these cases that a free and careful incision was a much safer method of evacuating the fluid.—Dr. SHINGLETON SMITH mentioned an interesting history which had come to his knowledge. A patient in early life was supposed to be dying of tubercular peritonitis: she recovered, but some ten years later had spinal disease which caused considerable angular curvature: ten years later again she had hæmoptysis and indications of tubercular disease of lungs, together with a tubercular intercostal abscess. Death occurred some twenty-two years after the first indications of abdominal tuberculosis, but there was no return of the peritoneal symptoms.—Dr. J. O. SYMES said that in other collections of tubercular fluid it was noteworthy that evacuation was followed by rapid disappearance of tubercle bacilli. Thus pus aspirated from a tubercular hip-joint might be found crowded with bacilli, but if the discharge were examined twenty-four hours after opening the abscess the discovery of the bacilli

[1] *St. Thomas's Hosp. Rep.*, 1892, xx. 25.

would be a matter of great difficulty.—Mr. PAUL BUSH mentioned that in operating on these patients he endeavoured to admit as much air as possible into the peritoneal cavity, and that he had observed that the mere evacuation of fluid was often not sufficient to obtain a cure.—Dr. E. H. E. STACK remembered a case at St. Bartholomew's Hospital in a young man who, without ascites, had chronic intestinal obstruction which no medical treatment relieved. An incision was made through the abdominal wall, and the intestines were so matted that nothing further was done; but within a few days the obstruction was relieved, and in a few weeks the boy seemed quite well, and he was still well a year afterwards.—Dr. F. H. EDGEWORTH called attention to the statement of Fagge to the effect that the majority of cases of ascitic tubercular peritonitis are cured by the application of linimentum hydrargyri on lint to the skin of the abdomen.—Dr. MICHELL CLARKE said that he agreed with Mr. Morton that the majority of these patients got well from the immediate attack. Operation was unnecessary unless there was ascitic fluid, and then a certain time should be allowed for medical treatment to be carried out before operation was undertaken. If, however, an extreme amount of fluid was present so as to cause pain from distension, the abdomen should be opened without waiting. He mentioned a case in which a large quantity of ascitic fluid was absorbed as the result of extensive blistering of the abdominal wall, occurring from the application of a carbolic pad as a preliminary to operation. Tuberculous disease of the lungs, or persistent diarrhœa indicating intestinal ulceration, as a rule, contra-indicated operation. In these cases, as in a patient lately under his care, death might take place from obstruction of the intestine through adhesions or bands. Though the immediate prognosis of an attack of tuberculous peritonitis was good, the ultimate issue of the case was doubtful; three instances had occurred to him in the last three years in which the lungs became affected.—Mr. J. EWENS spoke in favour of blistering the abdomen with mercurial dressing in all cases of fluid in the abdomen; he had seen very good results. In some cases of ascitic fluid, when digitalis, squill, and other direct diuretics failed to reduce the swelling, small doses of mercury, given to the extent of affecting the gums, produced immediate diminution of the fluid.—Dr. R. C. LEONARD asked whether it was possible to exclude tubercular lesions of the intestine in cases of tubercular peritonitis, and whether if it was suspected operation was contra-indicated. He quoted Dr. Whitla's results with cod-liver oil in these cases.—Dr. C. ELLIOTT mentioned that in cases of tubercular peritonitis the secretion of urine was usually considerably diminished, and this fact he had found useful for diagnosis in obscure abdominal cases. For instance, he had once ventured on this ground to question the accuracy of his surgical colleagues in the case of a young woman who had been admitted for a supposed ovarian cyst. When operated upon, as he expected, simple peritoneal fluid was let out, and the patient made an excellent recovery. His treatment accordingly aimed at increasing the urinary excretion, and for this purpose he usually employed infusion of broom, combining it with iron, and the results were satisfactory.—Dr. WALDO, in reply, said that in cases where operation was not considered advisable he used lin. hydrargyri and a dry diet.

Dr. WALTER SWAYNE showed a specimen of diffuse sarcoma of the uterus with complete inversion. The patient, a nullipara, aged 17, was admitted to the Royal Infirmary with what looked like a piece of placenta protruding from an intact vaginal orifice. This was found to be immovable and to consist of part of the fundus covered with a

placenta-like growth, a section from which showed that it was composed of mixed spindle- and round-celled sarcoma. The growth covered the whole of the body of the uterus, which was completely inverted and rreducible. A large vesico-vaginal fistula was present, the opening being about the size of a shilling. As the growth appeared to have infiltrated the surrounding parts, it was dealt with by removal of the growth from the fundus by scissors and curette. The patient improved markedly in health after this; but was readmitted three months later with recurrence of the growth, and again treated in the same way. Improvement again followed the removal; but four months later the patient was readmitted, and died on the third day after arrival of asthenia. While sarcoma of the uterus was rare, and inversion also rare, diffuse sarcoma of the fundus uteri was specially apt to cause inversion.—Dr. W. H. C. NEWNHAM said that inversion so complete as shown in this specimen must be extremely rare. He had only met with *five* cases of complete inversion: four were produced by the midwife pulling upon the cord; these were admitted into the Hospital, replaced, and all recovered. The other was produced by the dragging down of a large fibroid tumour, which was sloughing and projecting from the vulva. He passed the wire of an ecraseur round what he believed to be the neck of the tumour and removed it. On looking at the specimen, he found he had also removed the upper half of the uterus with the Fallopian tubes in addition to the tumour. He did not take any further operative steps, and strangely enough the patient recovered absolutely without a single bad symptom or rise of temperature.

Dr. E. H. E. STACK showed a specimen of retro-pharyngeal abscess. The child was 2½ years, and had been ill a fortnight before admission. He came in under Dr. Shaw and seemed to be a case of diphtheritic laryngitis. The fauces looked natural. There was so much recession that tracheotomy was decided on almost at once, but on the first stroke of the knife he cried with such a good voice that it seemed evident there was no laryngitis. Exploring with the finger, a retro-pharyngeal abscess was felt and opened from behind the sterno-mastoid, several ounces of pus were evacuated, and very soon the breathing was relieved and he could swallow; but in a day or two he died, not having been able to recover the serious dose of septic infection he had received. The specimen shows no evidence of tubercle of the spine or other evidence of the cause of the abscess.

Dr. BERTRAM ROGERS read a paper on a case of thrombosis of the portal vein (*see* page 107 of the current number).

Mr. PAUL BUSH read a paper on some peculiar operation cases in lunatics, which will be published in a subsequent number.

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*May 10th*, 1899.

Dr. A. J. HARRISON in the Chair.

Mr. PAUL BUSH showed a boy with a marked displacement of the right scapula, which was raised about 3½ inches and rotated, the lower angle of the bone being situated over the spine of the vertebræ; there was no winged condition of the scapula. He considered the case was one of spasm of the trapezius muscle. A clear skiagram showed that the upper vertebræ were drawn over to the affected side.

Mr. J. LACY FIRTH showed a case of cervical ribs present on both sides, but more conspicuous on the left side. There were some signs

of pressure on the brachial plexus and the subclavian artery on the left side.—Mr. ROGER WILLIAMS said a few years ago Prof. Debierre read a paper at the International Medical Congress on "The Human Thorax: is it regressing?"[1] In support of his views, he referred to man's lost cervical and abdominal ribs, regarding specimens such as that shown this evening as due to reversion. The first and the two last ribs were normally of stunted and imperfect formation, indicative of tendency to disappear; and sometimes the first rib had no connection with the sternum, or it was represented only by a fibrous band. The chest muscles, especially the intercostals and those over the ribs, presented signs of regression in the great abundance of their tendinous structures. Similarly the thoracic (dorsal) nerves were seldom complete, for certain of them were wanting in 81 out of 100 cases; and nerve roots were defective in many cases. Mr. Williams had been specially interested in this subject, because his studies in polymastia had independently led him to a similar conclusion, he having shown that man had lost six pairs of mammary glands from the front of the thorax, three from above and three from below the normal pair, and traces of these lost mammæ occasionally reappeared owing to reversion. From the great thickening of the abnormal rib structure in the case exhibited, and from the fact that pressure-symptoms had been noticeable of late, he thought the redundant rib was growing in a very irregular manner; and in many cases irregular osseous growths, like exostoses, had resulted from the abnormal evolution of these formations.

Dr. W. H. C. NEWNHAM showed two specimens from the same patient —a large ovarian cyst, which was pressing on the bladder and rectum (being wedged down in the pouch of Douglas), and a fibroid uterus. The patient, aged 40, had one child thirteen years ago, and was sent by Dr. E. Walker for complete obstruction to micturition and partial obstruction to defecation. The ovarian tumour was distinctly felt in the pouch of Douglas. On April 20th he removed the cyst, also the fibroid uterus, by the operation of intra-peritoneal hysterectomy. The right ovary he left behind, it being apparently healthy. The woman recovered without a bad symptom, and was walking about the ward eighteen days after the operation.—Mr. C. A. MORTON said that evidently the ovarian cyst, which he understood had been supposed to be a myoma before operation, was the cause of the pressure-symptoms, and he did not think any need had been shown for performing hysterectomy. He thought that the mere fact that the abdomen had been opened was not sufficient reason, for the great majority of myomata never caused any trouble at all, and unless they grew very large, or caused pressure-symptoms or serious hemorrhage, there was no need to interfere with them. He quoted from Mr. Bland Sutton's recent papers advising removal of every myoma just as we remove every ovarian cyst, and he contended that a surgeon who did this would be likely to have a run of simple cases, and that his results by the intra-peritoneal method could not be compared with those of surgeons who only operated on very large tumours or those causing pressure-symptoms or serious hemorrhage by the extra-peritoneal method; and he referred to the mortality of one such operator who had had a more successful run of cases by the extra-peritoneal method than Mr. Bland Sutton by the intra-peritoneal. He also pointed out that the mortality in Bland Sutton's twenty-eight cases was 7 per cent., and that this was a high mortality for ovariotomy at the present time, and that therefore the mortality of the intra-peritoneal method

[1] *Atti d. xi. Cong. med. internaz.*, 1894, ii. Anat., 12.

could not be said to be the same as that of ovariotomy. Mr. Morton also referred to the dreadful picture of the results of the extra-peritoneal method drawn by Dr. Newnham in his recent paper in the *Journal*,[1] and said he ventured to think it was altogether an exaggeration. He asked, what evidence was there that dragging on a pedicle had ever caused peritonitis? and denied that fetid pus was discharged from the pedicle, or that there was a danger of pus leaking into the peritoneal cavity and causing peritonitis. He asked if there was no possible risk of peritonitis by the intra-peritoneal method from septic infection from the interior of the uterus, and if one could ignore the risk of injury to the ureters in the ligation of the uterine arteries? He did not wish to plead for the extra-peritoneal method in all cases, but mentioned some conditions in which it might be an advantage, and referred to one of his own cases treated by that method, with success, in which the tumour was very large—reaching up to the costal margin,—and in which the operation was rendered difficult by intimate adhesions to the bladder, and an expansion of the broad ligaments so that he was glad to use the serre-nœud.—Dr. JAMES SWAIN said that it was an easy matter to criticise another man's work when the specimen appeared on a plate, but the operator could best determine the right course of action to pursue, for at the time of operation we might consider it desirable to do that which might afterwards appear to others to be unnecessary. Speaking of the removal of fibroid tumours of the uterus in the abstract, he thought that the surgeon who performed hysterectomy in such cases should always be able to give a good reason for his action apart from the mere presence of a tumour. With reference to the battle which was being waged between the extra-peritoneal and the intra-peritoneal treatment of the pedicle in hystero-myomectomy, he felt that statistics were not altogether trustworthy, especially as such men as Bland Sutton apparently favoured the removal of all myo-fibromata, apart from their size or symptoms. He thought that of more value than statistics was the significant fact that most operators all over the world were now adopting the intra-peritoneal, or rather the retro-peritoneal, method. Thanks to the use of antiseptics, the employment of the clamp in extra-peritoneal hysterectomy had not been attended with such disastrous results as had accompanied the use of the clamp in the early days of ovariotomy. The extra-peritoneal method had been most successful, and he had not seen any of the unpleasant accompaniments which had been said to follow this mode of treatment. Each method appeared to be attended with good results, and he thought that the balance in favour of the intra-peritoneal method was to be looked for not so much in a diminished mortality as in greater precision in operating, a more speedy convalescence, and a lessened tendency to ventral hernia. He had recently adopted the retro-peritoneal method, and would continue to use it in suitable cases, for he regarded it as the operation of the future. At the same time, he had had such successful results with the clamp that he did not think it should be entirely discarded, for he thought there were cases where this method might advantageously be adopted, though not as routine treatment. The question was in a transition stage, and he declined to pin the whole of his faith to a pedicle clamp with the "extra-peritonealists," or to cast it free in the abdomen with the "intra-peritonealists." Our duty was to get the patient well by the best means at our command, and all would prefer to do a successful operation by what might be considered an incomplete technique, rather than to perform a surgically

[1] 1899 xvii. 8.

perfect operation resulting in the death of the patient.—Dr. WALTER SWAYNE was of opinion that it was impossible to say from seeing pathological specimens after operation whether operation was indicated in a particular case or not. It is a matter of experience that the most serious symptoms are not always produced by the largest tumours. He had now under his care a patient suffering from a fibroid which reached nearly to the ensiform cartilage, and was accompanied by profuse hemorrhage; by treatment and natural processes (the menopause) the hemorrhage and general symptoms soon ceased and the tumour retrogressed. The patient refused operation, perhaps wisely. At the same time small tumours produce occasionally very severe symptoms, and in any case when pain produces such disturbance that the patient is prevented from earning her living and her life is made a burden to her, then operative removal is imperative. He thought that if Dr. Newnham had not removed the uterus and the patient's symptoms had been unrelieved, his position as regards the patient would not have been a pleasant one. It appeared to him that the question of what was to be done at the operation must be left to the operator, and could not be settled by the inspection of a specimen previously removed by those unacquainted with the particular symptoms present. —Mr. T. CARWARDINE spoke in favour of the intra-peritoneal method of treatment of the pedicle in hysterectomy. With regard, however, to the extra-peritoneal treatment of the stump, any moisture and suppuration in the stump are usually due to faulty procedure and after-treatment.—Mr. ROGER WILLIAMS thought the term "hysterectomy" ought to be restricted to total extirpation of the uterus. The application of this term to all sorts of other operations comprising partial removal of the uterus tended to produce confusion. Dr. Newnham's case was one of amputation of the myomatous corpus. The small size of the tumours, the fact that the largest of them was connected with the fundus by but a slender pedicle, and that the other two tumours were of sub-peritoneal evolution, led him to ask the author why he had preferred amputation of the uterus to myomectomy, the procedure which Mr. Williams would have preferred, as it would have left the uterus intact, and was safe and efficient. Mr. Williams said it was misleading to compare statistics as to mortality, unless like things were compared with like things. The class of cases a surgeon had to deal with who undertook to remove every myoma, as soon as its presence could be recognised, was totally different from the class of cases that had to be dealt with by those who only operated when urgent symptoms arose. The former had to deal only with small tumours without extensive adhesions, and the mortality from such operations was from 5 to 10 per cent. In these early cases the condition of the uterus and its adnexa differed but little from the normal. In the other class of cases, however, the tumours were often of great size, very vascular, extensively adherent, inflamed and otherwise complicated, so that equally good results could not fairly be anticipated. In most of the former class of cases Mr. Williams thought operation unnecessary and unjustifiable. Hysterectomy, as a conservative operation, was a remedy worse than the disease it was meant to cure.—Dr. NEWNHAM, in reply, said it was a matter of opinion as to whether this was the right operation for this patient. She was complaining, in addition to her other troubles, that she had to keep her bed for ten days every month on account of the uterine hemorrhage. Supposing he had left these fibroid tumours, would she not rightly have returned complaining he had not cured her of her ailments. He did not think it possible that the ovarian cyst was the cause of the hemorrhage. In all probability the myomata would grow to a large

size in a woman whose age is only 40. He did not say that it is necessary to remove every myoma, for he had dozens of women attending as out-patients, and not one of them did he propose to operate on, because they had no serious symptoms. Neither did he say that every case that is undertaken must be done by the intra-peritoneal method, each case should be decided on its own merits; but he did think that intra-peritoneal hysterectomy is the operation of the future. He thought that if he had attempted to enucleate these fibroids from the uterus, as Mr. Williams suggested, the hemorrhage would have been more profuse, and, in his opinion, the danger of the operation would be greater than that of intra-peritoneal hysterectomy.

Dr. T. FISHER showed the following specimens:—(1) A pancreas containing several calculi from a man, aged 58, who died in the Bristol Royal Infirmary of senile gangrene. Apparently the calculi had given rise to no symptoms. (2) One of fibroid myocarditis, from a young man, aged 18, who had died suddenly while at work. There was disease of the aortic valves, but no affection of the coronary arteries. The chief points of interest were—firstly, that the fibroid disease was with very little doubt due to rheumatism; and, secondly, that, as so commonly occurs in cases of fibroid disease in later life, the patient died suddenly. (3) A specimen of broncho-pneumonia breaking down into cavities. Dr. Fisher thought that many cases of so-called dilated bronchial tubes are really the sequence of actual lung-destruction consequent upon broncho-pneumonia. (4) Specimens of sarcoma of the cæcum and of the ileum.—Mr. ROGER WILLIAMS said much interest attached to examples of malignant disease of the cæcum and small intestine, on account of their variety. Of 1,066 primary sarcomata tabulated by him, there was not a single instance of sarcoma of the small intestine. In 1892 Madelung reported three cases, and gave references to eleven others. Mermet, in 1896, reported a case of sarcoma of the jejunum in a woman, aged 32, who died the day after resection of the diseased bowel. She suffered from pain and diarrhœa, but not from obstruction. Twenty-three other cases were cited. Since then a few others had been reported. Several cases had been met with in quite young infants. In Stern's patient—an infant only a few days old—the disease presented as polypoid angio-sarcoma of the ileum, which caused death by intestinal obstruction. He thought these polypoid sarcomata generally arose from congenital adenomata of the intestinal mucosa.—Dr. P. WATSON WILLIAMS remarked that dilatation of the bronchial tubes, due to paresis of the muscular coat, was usual in bronchitis of the smaller tubes and broncho-pneumonia, and almost invariably found in fatal cases, and in this way the great majority of dilatations of bronchial tubes originated. In a comparatively few cases, as in the specimen shown by Dr. Fisher, the dilatation was due to the action of various micro-organisms leading to erosion or destruction of the bronchial wall and the neighbouring pulmonary tissue.

Dr. BERTRAM ROGERS showed two microscopic sections of the liver of a child. The patient had been for about eight weeks in the Hospital, when she developed a high temperature and died. The only symptoms were fever, an enlarged liver and slight jaundice. The liver *post mortem* presented a very mottled appearance, parts being fatty and parts very deeply congested, and in places a deep red from hemorrhages. Under the microscope, there were large patches where the liver substance seemed to have disappeared, leaving only a fine reticulum of connective tissue. There were extensive small hemorrhages into the substance of the liver.—Dr. T. FISHER, in connection with this

case, showed a drawing he had made of a very similar condition he had found in a case of heart disease.

Dr. E. H. E. STACK showed the following kidney specimens:—Two showed abscesses following bladder disease, one acute, the patient having only lived nine days after he broke his back. Two cases show hemorrhage in the pelvis of the kidney, the first from a case of purpura, under Mr. Munro Smith, in which the source could not be discovered. The patient was a man who had epistaxis, melæna and hæmaturia, as well as extensive hemorrhages in skin and muscles. Microscopically, the blood was normal. The second is from a case presented to the Infirmary by St. Bartholomew's Hospital—it is a kidney from bubonic plague. The two specimens are very much alike, the pelvis and ureter being filled with blood-clot. Two cases show adenoma of the kidney—one a single one, and the other multiple small ones. Two cases show hydronephrosis—one from stone impacted in the ureter, the other much larger, and for which, although the ureter was found by operation to be quite occluded, no cause could be discovered. Two cases show dilatation of the ureters, both from babies. No cause can be assigned for this, as there is no obstruction to the flow of fluid from ureter to bladder. One case of small multiple sarcomata from a child who died of diarrhœa, no other growth found. The last case is one of thrombosis of the renal vein. The child died of infantile diarrhœa. It is interesting in the light of recent bacteriological research on the streptococcus nature of this variety of diarrhœa. Dr. Symes grew from the clot many colonies of streptococci.

Dr. W. H. C. NEWNHAM read a paper on "Removal of one Ovary—with Cases." The record of the following cases may be of interest, as they include some women who have been under treatment for long periods (occasionally extending to years) by pessaries and various intra-uterine medication without relief. He simply included cases of painful prolapsed or inflamed ovary on one side. The operation for the removal of the diseased organ is simple, takes a very short time, and in the cases given below appears to have relieved all the symptoms and changed the patient from a chronic invalid to a worker.

(1) S. J., aged 26, laundry-maid, single. Has suffered with pelvic discomfort for eleven years,—much worse the last six, especially during catamenia. The pain was always on the left side. She had been previously treated with a pessary after some intra-uterine application. On April 7th, 1892, he removed the ovary, enlarged and deeply grooved apparently by the edge of the Hodge's pessary. She left the Hospital well on May 17th, and continues in good health.

(2) K. T., aged 25, unmarried, was admitted complaining of intense pain on the right side and down the right groin. He removed a large cystic and prolapsed ovary of the right side on August 10th, 1892, and the patient left the Hospital well on September 12th.

(3) A. B., aged 28, unmarried, came with a history of gonorrhœa some six years previously. She complained of intense pain in the right ovarian region. He removed a large inflamed right ovary on March 19th, 1898. She left the Hospital well on April 27th, 1898.

(4) F. O., aged 26, married. Had been ill for three years, complaining of dyspareunia and menorrhagia. Has had no children. He removed an intensely painful prolapsed ovary on the right side on April 21st, 1898, and patient left the Hospital on May 28th, 1898, quite well. She is now six months pregnant.

(5) M. L., aged 32, waitress, unmarried, with a history of gonorrhœa. Nine years ago she had first child. For the last eight years has been constantly in bed with some inflammatory attacks in the lower

part of the abdomen. *Per vaginam* on right side was felt a swelling, about the size of a small orange, which was acutely painful. He removed the right ovary on December 20th, 1898; it was very large and congested, and the tube itself was much swollen. For the first three days after the operation patient was very sick, in great pain, and distended to an uncomfortable degree. This all subsided under appropriate treatment, and patient left the Hospital quite well on January 17th. She now appears to be in perfect health.

(6) A. J., aged 32, married ten years, has had one child. Has had pain in left groin for twelve years. He removed a large tender and prolapsed ovary on the left side on February 20th, 1899, and she left the Hospital quite well on March 24th, 1899.

(7) M. R., aged 25, single, came with a history of localised peritonitis. On examination he found a large inflamed and apparently adherent ovary on left side This he removed August 20th, 1898, with some difficulty, as the adhesions were very dense all around. Patient, however, recovered without a bad symptom, and left the Hospital on September 28th, 1898, quite well.

(8) J. I., aged 28, had suffered from abdominal pain and discomfort for four years in the region of the left ovary. She is a married woman and has had three children. He removed a cystic ovary from the left side on April 12th, 1899, and patient is now well.

Dr. WALTER SWAYNE considered that there were many useful points to be noticed in connection with the series of cases. The first case illustrated very well the importance of a correct use of pessaries; it should be an axiom that a pessary should never be used if it pressed on solid visceral structures, *e.g.* uterus or ovary; intra-uterine applications also should be avoided, except after free dilatation and provision for drainage. In any case where symptoms of one-sided tenderness on pressure, backache, dysmenorrhœa, sterility, and dyspareunia were present, the condition of the ovary, if felt to be enlarged, should be investigated by operation, unless the symptoms were alleviated by rest and local treatment; in a large number of these cases, even when temporary alleviation took place, operation was ultimately necessary. He mentioned a case in which he removed the left ovary from a patient suffering from the above symptoms. On bringing the ovary into the wound it was seen to be cystic: the cysts were punctured, and the fluid contents evacuated; but as the diseased portion proved more than one-half of the ovarian substance, instead of removing the cystic portion from the ovary and returning the remains of the latter after suture, he removed the entire ovary. The patient was able to go home on the twenty-first day after operation, perfectly well. The ovary at present might be seen in the museum.

J. PAUL BUSH, *Hon. Sec.*

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## Devon and Exeter Medico-Chirurgical Society.

*November 18th*, 1898.

Dr. P. M. DEAS, President, in the Chair.

The PRESIDENT read a paper on "Sleep-producers and Sedatives." He called attention to the large number of drugs that were on the market, and to the fact that every doctor had his favourite one. Often the drug acted in the way of hypnotic suggestion. The doctor told the patient that he was go ng to give him something that would send him

to sleep, and consequently the patient slept. The subject of the treatment of insomnia was most important, as the condition was on the increase. The following varieties of insomnia were distinguished: (1) Psychical or emotional insomnia, due to grief, &c.; (2) insomnia in connection with bodily disorder, such as pain, fever, diseases of the heart or urinary system, eczema, with errors of diet, such as abuse of tea, coffee, or alcohol; (3) insomnia which precedes or follows insanity. These cases are apt not to get treatment sufficiently early. *Physiology of sleep*.—According to the latest theory, the cortical cells or "neurons," and their processes "dendrons," are not in organic connection with the nerves which bring up afferent stimuli and carry away efferent orders. This is important with regard to the views held as to sleep, dreaming, and somnambulism. The essence of sleep is that the neurons are out of action. The telephonic exchange ceases to exist during sleep, and the lower nerve centres in the brain and spinal cord are depressed, together with a general lowering of the vital processes. As to the proximate cause of sleep, there are various theories; namely, that it depends on periodicity, fatigue of brain cells, or increased supply of blood to the brain. The last is certainly not true. There is diminished supply and pressure of blood in the brain due to contraction of vessels. The inhibiting action of the highest centres is in abeyance. Dr. Deas believed that sleep was due to the absorption by neurons from the blood of some material circulating in the blood, and that when a certain amount has accumulated sleep is produced. The conditions which tend to insomnia are—1, excitement and over-action; 2, depression (*a*) central or mental, (*b*) peripheral or bodily. In these conditions there is a state of vascular excitement, and the neurons are over-stimulated. The circulation is kept at such a state of tension that the neurons cannot be withdrawn from the irritation of the nerves, and their inhibiting action is still maintained. A drug may act as a sedative, and produce sleep, by putting the body into a more favourable condition for sleep. Unfortunately, nearly all sedatives are heart depressants. A sleep-producer acts directly on the neurons. He then called attention to some of the drugs available. *Bromides* had a remarkable effect in diminishing reflex irritation. Bromide of sodium, gr. 20, with tincture of lupuline ʒ i., was a good combination (at bedtime). In more urgent cases bromides must be given several times a day. In sleeplessness in connection with a rapid neurotic heart, digitalis may be combined with bromides. Bromide of potassium is the most depressing, and so is useful in cases of sexual excitement (with liq. extract of salix nigra). It is very useful in acute mania. *Chloral*.—Dr. Deas did not recommend this drug strongly. Chloral is better as a sleep-producer than as a sedative. It is uncertain and very depressing; occasionally useful when combined with bromides. He laid stress on the importance of only giving sleep-producers at bedtime, and when the conditions are favourable for the production of sleep. *Trional* is a good sleep-producer, and there is very little risk in its use. Grains 25 may be given for 2—3 nights running, and then a smaller dose. *Sulphonal* wants very careful watching. It is a treacherous drug, and is not to be depended upon. It is a powerful sedative, and does best for violent cases of acute mania. It is very useful if given at regular intervals and with proper precautions. It tends to interfere with the secretions, and has a cumulative action. It paralyses the peristaltic action of the bowels. It has a very depressing effect on the nerve-centres, causing ataxia, &c. Aperients are necessary during its use. In conditions of excited circulation with weakness, causing insomnia, do not hesitate to give stimulants with the sedative. In conditions of depression, causing

insomnia—such as grief, melancholia, stupor, hypochondriasis, where there are vague feelings of discomfort, and mental pain—the neurons are in a state of irritation, very different from the feeling of comfort and well-being which precedes natural sleep. Here insomnia is well marked, and the depression is much worse during the sleepless hours. *Paraldehyde* is an ideal sleep-producer; it first stimulates the neurons, and then natural sleep is produced with no depression. In cases of melancholia with stupor, paraldehyde has sometimes a remarkable effect. After taking the drug the patient wakes up and talks for about ten minutes, and then falls fast asleep. The dose of paraldehyde is ʒi.; in exceptional cases ʒ iij. to ʒ iv. may be given, with liquid extract of liquorice to disguise the unpleasant taste. Dr. Deas did not advise drugs in all cases of insomnia. In cases of acute excitement ordinary means may act as well as drugs. The want of sleep is not so important in excited cases as in depressed cases. It may be necessary to prevent struggling, which would otherwise exhaust the patient. In general paralysis some authorities keep their patients during the stage of excitement in a condition of sulphonal intoxication, and so steer them into the haven of dementia. He did not advise the use of morphia or opium for insomnia without pain. These are narcotics, and not sleep-producers. In giving sleep-producers, give a sufficient dose that you think will produce sleep, and only at bedtime, and diminish the dose afterwards. In giving sedatives, begin with a small dose and go on increasing it. It is often more necessary to stimulate than to depress. Sleep is wanted, and not a condition of unconsciousness.

R. V. Solly, *Hon. Sec.*

## The Library of the Bristol Medico-Chirurgical Society.

*The following donations have been received since the publication of the list in March:*

*May 31st, 1899.*

American Dermatological Association (1) ... ... 10 volumes.
Dundee Medical Library (2) ... ... ... ... ... 1 volume.
L. M. Griffiths (3) ... ... ... ... ... ... ... 7 volumes.
Editor of *Illustrirte Rundschau der medicinisch-chirurgischen Technik* (4) ... ... ... ... ... ... ... 1 volume.
G. T. Jackson, M.D. (5) ... ... ... ... ... ... 1 ,,
E. D. Mapother, M.D. (6) ... ... ... ... ... ... 1 ,,
R. Shingleton Smith, M.D. (7) .. ... ... ... .. 1 ,,
E. H. E. Stack, M.B. (8) ... ... ... ... ... ... 1 ,,
Surgeon-General, United States Army (9) ... ... 29 volumes.
B. W. Walker, M.D. (10) ... ... ... ... ... ... 18 ,,
John Wright and Co. (11) ... ... ... ... ... ... 1 volume.

Unbound periodicals have been received from Mr. L. M. Griffiths. A framed picture has been presented by Mrs. Greig Smith; and unframed pictures have been given by Mr. H. Kerslake, Herr J. F. Lehmann, and Dr. William Warren Potter.

## THIRTY-SECOND LIST OF BOOKS.

The titles of books mentioned in previous lists are not repeated.

The figures in brackets refer to the figures after the names of the donors, and show by whom the volumes were presented, The books to which no such figures are attached have either been bought from the Library Fund or received through the *Journal*.

**Adams, J. H.** ... *Life of D. Hayes Agnew* ... ... ... ... ... ... ... 1892
**Adams, R.** ... ... *Illustrations of Rheumatic Gout* ... ... ... ... (8) 1857
**Allbutt, T. C.** [Ed.] *A System of Medicine.* Vol. VI. ... .. ... ... ... 1899
**Bailey, J. B.** ... *The Diary of a Resurrectionist*, 1811–12 ... ... ... 1896
**Barbour, A. H. F.** *The Anatomy of Labour* ... ... ... ... ... 2nd Ed. 1899
**Bettany, G. T.** ... *Eminent Doctors.* 2 vols. ... .. ... ... 2nd Ed. [1885]
**Bramwell, B.** ... *Anæmia and Diseases of the Blood-Forming Organs and Ductless Glands* ... ... ... ... ... ... ... 1899
**Brockbank, E. M.** *The Murmurs of Mitral Disease* ... ... ... ... ... 1899
**Brown, A. M.** ... *Elements of Alkaloidal Ætiology* ... ... ... ... ... 1899
**Bruce, J. M.** ... *Materia Medica and Therapeutics* ... ... [5th Ed.] 1896
**Bryce, J.** ... ... *On the Inoculation of Cowpox* ... ... ... ... 2nd Ed. 1809
**Burghard, W. W.** **Cheyne and F. F.** *A Manual of Surgical Treatment.* Part I. ... ... ... ... ... ... ... ... ... ... 1899
**Cheyne and F. F.** **Burghard, W. W.** *A Manual of Surgical Treatment.* Part I. ... ... ... ... ... ... ... ... ... ... 1899
**Crile, G. W.** ... *Surgical Shock* ... ... ... ... ... ... ... ... ... [1899]
**De Foe, D.** ... ... *A Journal of the Plague Year*... ... ... ... ... ... [N.D.]
**Evans, A. H.** ... *Golden Rules of Medical Practice* ... ... .. ... ... [1899]
**Feltoe, Rev. C. L.** *Memorials of John Flint South* ... ... ... ... (7) 1884
**Fernie, W. T.** ... *Animal Simples*... ... ... ... ... ... ... ... ... 1899
**Floderus, B.** .. *Om Medfödda Uretermissbildningar ur Kirurgisk Synpunkt* ... ... ... ... ... ... ... ... ... 1899
**Freeman, E. C.** ... *The Sanitation of British Troops in India* ... ... .. 1899
**Hawthorne, C. O.** *Some Aspects of the Mental Discipline Associated with the Study of Medicine* ... ... ... ... ... ... ... 1899
**Helferich, H.** ... *On Fractures and Dislocations.* (Tr. from 3rd Ed. by J. Hutchinson, jun.) ... ... ... ... ... ... 1899
**Herschell, G.** ... *Constipation* ... ... ... ... ... ... ... ... ... 1899
**Hime, M. C.** ... *Schoolboys' Special Immorality* ... ... ... ... ... 1899
**Hurst, A. M.** **Marshall and C. H.** *Practical Zoology.* 5th Ed. (Revised by F. W. Gamble) ... ... ... ... ... ... 1899
**Jackson, G. T.** ... *A Dermatological Bibliography* ... ... ... ... (5) 1891
*Katalog over det Norske Medicinske Selskabs Bibliotek—Tillægs No. 1* ... ... 1899
**Kirkes, [W. S.]**... *Hand-Book of Physiology.* 15th Ed. (Ed. by W. D. Halliburton)... ... ... ... ... ... ... ... 1899
**Leeuwenhoek, A. à** *Opera Omnia.* 4 vols. ... ... Editio Novissima 1719-22
**Mapother, E. D.**... *Papers on Dermatology, &c.* ... ... ... (6) 2nd Ed. 1899
**Marshall and C. H. Hurst, A. M.** *Practical Zoology.* 5th Ed. (Revised by F. W. Gamble) ... ... ... ... ... ... 1899

**Moure, E. J.** ... *De la Réunion immédiate du Pavillon de l'Oreille après la Cure radicale de l'Otorrhée* ... ... ... ... 1899
, ... *Sur un Cas d'Ostéo-Myélite Aiguë du Temporal consécutive à l'Influenza* ... ... ... ... ... ... 1899
**Newsholme, A.** ... *Vital Statistics* ... ... ... ... ... ... 3rd Ed. 1899
**Ogle, J. W.** ... *The Harveian Oration, 1880* ... ... ... ... ... ... 1881
**Osler, W.** ... ... *The Principles and Practice of Medicine* ... ... 3rd Ed. 1898
**Park, R.** ... ... *An Epitome of the History of Medicine* ... ... 2nd Ed. 1899
**Parke, T. H.** ... *Experiences in Equatorial Africa* ... ... ... ... ... 1891
**Pedley, R. D.** ... *The Hygiene of the Mouth* ... ... ... ... ... ... [N.D.]
**Prichard, J. C.** ... *The Natural History of Man.* (Ed. by E. Norris) 2 vols. ... ... ... ... ... ... ... 4th Ed. 1855
,, ... *Celtic Nations.* (Ed. by R. G. Latham) ... ... ... 1857
**Ratzel, F.** ... ... *The History of Mankind.* (Tr. from 2nd German Ed. by A. J. Butler) 3 vols. ... ... ... 1896-98
**Raynalde, T.** ... *The Byrth of Mankinde* ... ... ... ... ... ... ... 1604
**Roberts, C.** ... ... *Eastbourne as a Health Resort* ... ... ... ... ... ... 1899
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# Local Medical Notes.

## ABERGAVENNY.

Monmouthshire Asylum.—During the year 1897 this asylum increased the number of its patients by 37, and on the last day of the year it contained 1,012. Of the year's admissions 18 owed their insanity to moral causes, 21 to intemperance in drink, 45 to hereditary influence, and 42 to previous attacks. Courses of lectures on nursing are given by the medical officers, and eighteen of the staff entered for the examination of the Medico-Psychological Association, and seventeen of them obtained the nursing certificate. The committee express their "high appreciation of the services of Dr. Glendinning and his able assistants, Dr. Nelis and Dr. Black." At the meeting of the Monmouthshire County Council, held on May 3rd, it was decided to purchase at an approximate cost of £8,000 a farm adjacent to the county asylum for purposes of further development.

## BARNSTAPLE.

Public Health.—Mr. M. R. Gooding has been re-appointed Medical Officer to the Port Sanitary Authority.

## BATH.

ROYAL UNITED HOSPITAL.—At the Guildhall, Bath, under the presidency of the Mayor, the annual meeting of the Governors and others interested in the Bath Royal United Hospital was held. According to the report the number of in-patients that had been treated was 1,190, whilst in 1897 the number was 1,264. The out-patients numbered 8,209, whilst during the previous year the number was 8,988. An increase of subscriptions from factories and workshops was shown; but there had been a falling off in subscriptions and donations during the past year. Several improvements have been effected, the operating theatre and the new chapel having been refurnished and kitchens constructed.

EYE INFIRMARY.—At the annual meeting of the Governors of the Bath Eye Infirmary, the report showed that against 262 in-patients treated during 1897, 208 were admitted during the past year. £245, the amount of legacies received, and the balance in hand, which was a good one, had been carried to the capital account.

ROYAL MINERAL WATER HOSPITAL.—The annual meeting of this institution was held on May 1st, under the presidency of General Mainwaring. The report showed that during the past year 1350 patients had been admitted, the largest number in the history of the hospital; the average number in the hospital was 150, and the average stay of each was 40 days. The expenditure amounted to £5,514 and exceeded the income by £142. The balance in hand was £527. Colonel Vaughan was elected president for the ensuing year.

## BRISTOL.

HOSPITAL SUNDAY FUND.—In our last number we stated that the collection this year on behalf of the Medical Charities would exceed that of 1898, and we are pleased to say that about £500 more was obtained. This must be very gratifying to the organisers, who certainly worked very hard to make the fund a success. In only the second year of its existence, that the collections in the numerous places of worship in our city should contribute £1500 is good, but when compared with what is accomplished in other towns it is evident that much remains to be done to stimulate interest in our medical charities and their impoverished condition. Comparing the lists of last year and of this, it is a curious fact, and one of which no explanation has yet been given, that while the money received from Church of England churches is less than previously, that from Nonconformists has increased. It may be that the Nonconformist conscience has been awakened; if so, we hope that the Established conscience will be awakened next year.

ANNUAL REPORTS OF MEDICAL CHARITIES.—Since March all the Medical Charities have published their annual reports, and in all of them there is the same cry for more subscribers to carry on the work. The ever increasing debt of these institutions is a very serious matter, and must be faced. Several of them have employed legacies to pay current expenses—a proceeding which does not meet with the approval of everyone; but when the income year by year fails to meet the expenditure, something of this kind must be done.

THE PREVENTION OF CONSUMPTION.—The Committee mentioned in our last number have been at work, but not much progress has been made beyond a most excellent report on the condition of the city from a medical and legal point of view presented by Dr. Davies. We believe that this will be printed in the Medical Officer's annual report, so that at least every medical man as well as town councillor will have an opportunity of seeing how much consumption there is in Bristol now as

compared with forty years ago; and how we are still in a very impotent state as regards the inspection of meat or dairies. We regret that so little interest has been shown outside our profession in the matter, but it may be aroused later.

THE JUBILEE CONVALESCENT HOME will be opened, according to present arrangements, by the Queen in November. The Committee has got so far as to elect a Medical Officer, and out of a large number of candidates chose Mr. John S. Griffiths for the post. The interior is still undergoing alterations.

OBITUARY.—It is with deep regret that we learn that the plague in India has caused the death of Dr. Fenton Evans, who was some years ago a very able Medical Tutor at the School, and afterwards House Physician at the Royal Infirmary.

## BURNHAM.

PUBLIC HEALTH. — Dr. F. C. Berry has been re-appointed Medical Officer of Health.

## CARDIFF.

PUBLIC HEALTH.—Dr. E. M. Spencer has been appointed Medical Officer to the Penarth Sanitary District. Dr. R. Mathias has been appointed Medical Officer for the Pentyrch Sanitary District.

THE INFIRMARY.—At a meeting of the Cardiff Infirmary, held on April 12th, under the presidency of Dr. Edwards, it was decided that a sub-committee should report upon the proposed reception of paying patients in the institution. A recommendation of the medical board that no member of the honorary staff should hold office longer than twenty years was deferred for future consideration. It was decided that the supply of milk to the infirmary should be only from cows certified to be free from tuberculosis. Legacies to the amount of £2,100 have been recently received by the institution, and the reverse balance is now reduced to £2,900. A resolution was proposed at a special meeting of the governors that a deputation should approach the Mayor and County Council of Cardiff with a view to obtaining a grant of not less than £500 a year from the Council to the Infirmary towards maintenance expenses; but the resolution was rejected by a majority of ten.

PROPOSED SEAMEN'S HOSPITAL.—The Mayor of Cardiff has embarked upon a useful and praiseworthy scheme; namely, that of building and organising a Seamen's Hospital for the town. Already the sum of £16,500, including a generous donation of £10,000 from Lord Bute, has been raised, but £5,500 more are required before the work can be proceeded with. Cardiff is a wealthy town, and there is every probability that this sum will soon be forthcoming. Moreover, the object is so good a one that there can be no excuse for those able to do so from withholding their liberal support. The important shipping centre which the town has now become makes the needs of a Seamen's Hospital almost imperative, and hence the activity and enthusiasm displayed by the townspeople in the Mayor's enterprise. It is proposed to hold a bazaar in aid of the building fund in December next. We wish the new charity every success.

CONVALESCENT HOME.—The annual meeting of those interested in this institution was held at the Cardiff Town Hall on April 24th, under the presidency of the Mayor, Alderman T. Morel. The report showed that the receipts in 1898 were £1,453, and the expenditure amounted to £1,108. There still remains a deficit balance of £2,500 on the extension fund. There were 738 patients admitted, the average period for which each

remained in the Home being seventeen days. The cost of maintenance was 1s. 5d. per head per day. It was decided that a special committee should be appointed to devise means for raising funds to remove the debt upon the building.

District Nursing.—The ninth annual report of the Cardiff Branch of Queen Victoria's Jubilee Institute for Nurses has been issued. The Honorary Treasurer, Dr. Sheen, reports that the total cost of this excellent work was £883 9s. 6d., which was raised by various methods.

## CARMARTHEN.

Public Health.—The decision at the last quarterly meeting of the Carmarthenshire County Council to set up a Sanitary Committee, to whom is delegated the question of securing the appointment of a County Medical Officer of Health, is a long delayed step which will eventually bring this County Authority in line with its compeers throughout the country in matters of public health.

Obituary.—The death of Mr. James Rowlands in his eighty-fifth year occurred on April 10th. He received his medical training at St. George's Hospital, London, and was believed to be the oldest St. George's man living. For forty years he was surgeon to the prison at Carmarthen, and for many years also surgeon to the local infirmary. He was Coroner for a long period, and an Alderman and J.P. He was deeply respected and beloved by all classes of the community, and remained in practice until illness compelled him to retire about six months ago. He married in 1835, and celebrated his diamond wedding in January, 1895.

## CHELTENHAM.

Public Abattoirs.—The Medical Officer of Health for Cheltenham, Dr. J. H. Garrett, refers to the abattoirs question in his report for 1898. He asserts that it is not only nor chiefly to avoid a nuisance from filth and general insanitary conditions, such as may be prevented to a great extent by by-laws, that private slaughter-houses should give way to public abattoirs, but rather in order that the very necessary inspection of animals intended for slaughter, and of their organs and carcasses after slaughter, and of their mode of slaughter, should be rendered possible, and the seizure or setting aside of the flesh and parts of diseased animals be facilitated.

Tuberculosis.—Dr. Garrett points out that it would be misleading to the public to grant a Corporation certificate, which would be taken as a guarantee of the freedom of the products of a dairy from the germs of tuberculosis, whilst in reality our knowledge of the subject does not at present admit of the possibility of any such guarantee. This has prevented him hitherto advising the use of certificates in his district.

## DEVIZES.

Public Health.—Dr. Leonard Raby has been appointed Medical Officer of Health, *vice* Mr. E. N. Carless, deceased. Mr. J. T. Thomas has been appointed Medical Officer of Health for Wiltshire.

## DEVONPORT.

Public Health.—Mr. H. Gard has been appointed Medical Officer for the Northern Sanitary District.

Royal Albert Hospital.—A scheme has been prepared for extending and improving the Royal Albert Hospital at an estimated cost of £4,000.

Isolation Hospital.—The Devonport Town Council at their meeting on April 13th decided to endeavour to purchase seven acres of land adjoining the Infectious Diseases Hospital, which was built in 1882, and is in need of enlargement.

## EXETER.

DEVON AND EXETER HOSPITAL.—The special meeting of Governors of the Devon and Exeter Hospital dealt with a large number of questions of vital interest to all institutions of the kind. The Devon and Exeter Hospital has experienced a large amount of criticism recently, and a complete inquiry into its financial condition has taken place. At the meeting it was proposed to close one large ward, to decrease the yearly deficit. Discussion brought out the fact that the capital of the Hospital equalled upwards of £100,000, from which a yearly income of £3,000 was derived. In the face of this fact, a resolution in favour of resorting to other means of diminishing the adverse balance was passed, and it was also decided that a reinvestment of the capital should be considered. A proposal to open a paying ward did not receive much attention, and another suggestion for the more satisfactory admission of patients met with no definite result. Nevertheless, the meeting showed that amongst the governing body a distinct advancement has been made in realising the measures which tend generally towards progress and judicious administration.

WEST OF ENGLAND EYE INFIRMARY.—The foundation stone of the new West of England Eye Infirmary was laid by Mr. Franklin on April 11th, after a short service by the Bishop of Crediton. This infirmary was founded in 1808, and was the second in the United Kingdom devoted exclusively to diseases of the eye. In 1895 it was decided to entirely rebuild the institution, and property adjoining the infirmary was purchased for that purpose. The section now commenced will cost about £8,500, towards which £7,500 has been raised.

THE PREVENTION OF CONSUMPTION.—A useful leaflet, entitled *Advice on the Prevention of Consumption*, has just been issued for circulation among the people by the Health Department of Exeter, of which Dr. John Woodman is the Medical Officer of Health, and Drs. Edward A. Brash, George T. Clapp, and John Mackeith the Assistant Medical Officers.

## EXMOUTH.

DISPENSARY.—Dr. J. Shapland has been appointed Medical Officer, *vice* Mr. Reginald Martyn, resigned.

## FALMOUTH.

PUBLIC HEALTH.—Dr. W. K. Bullmore has been re-appointed Medical Officer of Health to the Falmouth and Truro Port Sanitary Authority.

## GLOUCESTER.

PUBLIC HEALTH.—The report of the Medical Officer of Health (Dr. Campbell) of the Gloucester Urban Sanitary Authority for 1898 has just been issued. Dr. Campbell estimates the total population of the city at 41,450, an increase of 284 in the year. The births numbered 1315—688 males and 627 females—compared with 1336 in the previous year. The rate is 31·7 per 1000, compared with 32·6 per 1000. There were 694 deaths as compared with 726, a rate of 16·7 as compared with 17·6 in the previous year. Dealing with the water supply, the report states that the three sources of supply now available are capable of providing twenty gallons per head per day for double the population now supplied. On the whole, the supply generally will, it is stated, compare favourably with that of the best supplied towns; and the only fault that can be found is that the Witcombe and Robinshood Hill supplies are not sand filtered as well as decanted, and that the Newent supply is not chemically softened.

GLOUCESTER GENERAL INFIRMARY AND GLOUCESTER EYE INSTITUTION.—At a quarterly meeting of this institution, held on March 30th, under the presidency of Colonel Curtis Hayward, the Chairman stated that during the past ten years the expenditure of the Infirmary had increased by £1,000 a year, while the income had only increased by £200.

DISTRICT NURSING.—The annual meeting of the Gloucester District Nursing Society has been held, under the presidency of the Dean. There was a good attendance, and the novelty of the proceedings was an address on the subject of "District Nursing" by Mrs. Clare Goslett. The Chairman, in addressing the meeting, remarked that general approval was sometimes not so profitable as a little wholesome abuse. Everyone approved of this most needful and helpful institution, but at the present moment they were from £30 to £40 to the bad. It has been decided to buy a house for the use of the nurses. The hon. secretary's report also contained a strenuous appeal for a larger income. The committee deplore the loss, by death, of Dr. Ancrum, vice-president of the Society since its institution, and of Miss Taynton, an energetic colleague.

## ISLES OF SCILLY.

MEDICAL MAGISTRATE.—Dr. T. Thornton Macklin, Medical Officer of Health for Scilly, has been appointed to the Commission of the Peace for the Isles of Scilly in the County of Cornwall.

## KEYNSHAM.

PUBLIC HEALTH.—Mr. F. W. S. Stone has been appointed Medical Officer for the Sanitary District of Kelston and Northstoke.

## LOOE.

PUBLIC HEALTH.—Dr. J. E. Webb has been re-appointed Medical Officer of Health.

## MAESTEG.

ACTION FOR LIBEL.—At the Glamorganshire Assizes, held on March 21st, before Mr. Justice Darling, a libel action was brought against Dr. John Davies, of Maesteg, by Dr. W. H. Thomas, J.P., of the same place. The cause of the action was the publication of a letter to the Bridgend Board of Guardians and also to a local newspaper, in which defendant complained of the absence of professional etiquette on the part of the plaintiff. The plaintiff claimed £1,000 damages. Eventually the defendant withdrew absolutely the statement which he had made against Dr. Thomas. In the result a juror was withdrawn.

We regret to record the sudden death of Dr. Thomas on April 13th.

## MERTHYR-TYDVIL.

PUBLIC HEALTH.—The Medical Officer of Health (Mr. Dyke) reports that during 1898 there were 2495 births registered, giving a rate of 34·7; of these 73, equivalent to a rate of 2·92, were illegitimate. Vaccinations were performed in 1870 instances by public vaccinators. There were 1409 deaths, compared with 1598 in 1897, equal to a rate of 19·5 per 1000, which is the lowest rate ever recorded in the district. The present population is 71,903, with 12,912 occupied houses.

## MIDSOMER NORTON.

PUBLIC HEALTH.—Mr. A. H. Whicher has been re-appointed Medical Officer of Health.

## NEWPORT.

PUBLIC HEALTH.—The Sanitary Committee of the Corporation has decided to continue for another term of five years the old system of dealing with street and trade refuse; viz., by tipping it on scavenging heaps instead of purchasing and erecting refuse destructors. Inquiries as to the taking of further land for cemetery purposes have brought in a valuation of ten acres of land belonging to Lord Tredegar at £3,750, in addition to the cost which would be imposed for drainage.

## NEWTON ABBOT.

PUBLIC HEALTH.—Mr. H. Goodwyn has been re-appointed Medical Officer for the Islington Sanitary District. Mr. R. H. Grimbly has been re-appointed Medical Officer for the Ipplepen Sanitary District. Mr. A. E. Hayward has been appointed Medical Officer for the Teignmouth Sanitary District.

## PENZANCE.

VACCINATION.—At the meeting of the Penzance Board of Guardians, held on April 13th, it was stated that £102 would be paid for vaccination fees in the western district of the union, as compared with £15 paid for the whole union in the corresponding quarter of last year. One of the members thought that the names of persons vaccinated by the public vaccinator should be published.

## PLYMOUTH.

BOROUGH ASYLUM.—At a meeting of the Plymouth Town Council, held on May 8th, the report for 1898 of the Visiting Committee of the Plymouth Borough Asylum at Blackadown was presented. This stated that the result of the recent controversy between the Guardians and the Council with regard to the weekly rate charged for pauper patients from Plymouth was that the Council in future would pay £1000 a year extra and the Guardians £1000 per annum less than formerly. The weekly maintenance rate of patients had been reduced from 12s. 1d. to 11s. 2d.

PROPOSED HOME FOR INCURABLES.—At an influential meeting, held at Plymouth on March 29th, it was decided to establish a Home for Incurable Patients at Plymouth, and a committee was appointed to prepare a scheme for the purpose to be submitted to a public meeting to be held shortly.

## PONTYPRIDD.

PUBLIC HEALTH.—Mr. D. N. Morgan has been appointed Medical Officer to the Tonyrefail and Gilfach Sanitary District.

## PORTISHEAD.

SEWERAGE SCHEME.—These works have been completed, and the house connections are being rapidly proceeded with. The sewage, without treatment of any kind, is discharged into the river Severn at a point about a third of a mile from the shore. Valves are provided to keep the sea water out of the sewers; and the low-level sewers are distinct from the high-level, the sewage having to be lifted from the former to the latter. The total length of main sewers on the high and low levels is about eight miles. The whole works cost, approximately, £16,500.

## SWANSEA.

SWANSEA HOSPITAL.—Mr. C. N. Chadborn has been appointed House Surgeon.

DIPHTHERIA EPIDEMIC.—In the recent diphtheria epidemic at Swansea a good effect was produced by closing the elementary schools.

## TAUNTON.

TAUNTON AND SOMERSET HOSPITAL.—Dr. A. C. Anderson has been appointed Assistant House-Surgeon.

## TAVISTOCK.

RESPIRATORY DISORDERS AMONG ARSENIC WORKERS.—Since the decline of the copper and tin mining industries in Cornwall, a number of arsenic works have been in operation on the sites of the old mines, and the attention of the Tavistock Board of Guardians has been directed to the large number of persons employed at these works who have been disabled and have come upon the parish for support. Dr. C. C. Brodrick, Medical Officer of Health for the Tavistock Rural District, and Dr. Albert Bowhay, Medical Officer of Health for the Calstock Rural District, at the request of the Board, have investigated the state of affairs in the parish of Calstock, and find that a large number of persons once employed at the arsenic works are in receipt of parish relief, and are suffering from respiratory diseases attributed to the effect of arsenic fumes. They have also discovered that out of 100 persons employed at these works who have died in the last three years, 83 have died of respiratory diseases. On visiting the works they observed that the furnace men used no protection at all, while the millers and grinders had the mouth and nostrils covered only with lint and a handkerchief. They recommend the use of a wire mask covered with gauze by all those employed at the works. The Board of Guardians have sent copies of this report to the managers of the works, and also to the Local Government Board. These two medical officers have for many years been familiar with the arsenic works, and are well acquainted with the medical history of the workers, so that their opinion is deserving of serious consideration. (For further information relating to this subject, see *British Medical Journal*, April 15th, 1899, p. 926.)

## TOTNES.

NEW HOSPITAL.—At the meeting of the subscribers of the Totnes (Devon) Cottage Hospital, held on March 22nd, under the presidency of the Mayor (Dr. G. J. Gibson), the Duke of Somerset's offer of a site for a new hospital at Bridgetown was gratefully accepted, and it was decided to advertise for plans for the new building.

## TROWBRIDGE.

PUBLIC HEALTH.—At a special meeting of the Urban Council held last week, consideration was given to the question of the proposed formation of an isolation hospital district for the urban district, the Melksham urban district, and the rural district of the Melksham union. A resolution against joining the hospital district was passed unanimously.

## TRURO.

PUBLIC HEALTH.—At the meeting of the Sanitary Committee of the Cornwall County Council, held at Truro on April 13th, under the presidency of the Hon. John Boscawen, Mr. Martyn drew attention to the desirability of appointing a Medical Officer of Health for the County. The chairman agreed as to the necessity of such an appointment, and upon his motion a sub-committee was elected to act.

TUBERCULOSIS.—The Medical Officer of Health for Truro Union (Dr. Bonar), in his report to the Sanitary Committee, recently referred at length to tuberculosis in cows, and stated that one cow's milk with tubercle mixed with the milk of twenty healthy cows would contaminate the whole. He also referred to the importance of the tuberculin test,

and said it would be an advantage to every milk purveyor to be able to say that his dairy was free from suspicion. Commenting on the report, Dr. Bonar said he thought that all dairies from which milk was brought to Truro should have their cows tested. Those who lived by milk-selling ought to be able to say they had had their animals tested, and that these were free from tubercle. Dr. Bonar said the time was coming when no one in Truro or anywhere else would buy milk from cows that had not passed the test.

CORNWALL NURSING ASSOCIATION.—The Earl of Mount Edgcumbe presided at the annual meeting of the Cornwall County Nursing Association, recently held at Truro. There was a large and influential attendance. The village nurses, trained by the Association free of cost to themselves, have been started with a view to meet the want of trained nursing in scattered rural districts, where it is impossible to raise the sum required to maintain a Queen's nurse. The minimum time required for training village nurses is six months, but the Executive Committee have decided in some instances to allow twelve months instead, so as to better qualify them for their work. These nurses are required to pass the examination of the London Obstetrical Society, and to obtain its certificates. Arrangements have been made to give the village nurses six months' additional training in the South Devon and East Cornwall Hospital, Plymouth, and the Royal Cornwall Infirmary, Truro, subject to certain conditions. The Association has now altogether expended £229 on the training of nurses, and has received a grant of £100 from the Cornwall Technical Education Committee.

## WEYMOUTH.

PUBLIC HEALTH.—Mr. James Nimmo has been appointed Public Analyst to the Borough of Weymouth and Melcombe Regis.

## A Memorial to Dr. Joseph O'Dwyer.

A representative committee has been formed for the purpose of doing honour to the memory of Dr. Joseph O'Dwyer. Dr. Geo. F. Shrady has been elected permanent Chairman, and Dr. Alfred Meyer permanent Secretary, and the following Committee on Scope and Plan was appointed: Dr. Dillon Brown, Chairman, and Drs. Robert Abbe, R. G. Freeman, L. Emmet Holt, and Louis Fischer. The memorial will probably take an educational form.

## The "Index Medicus."

The announcement has just been made that with the current number the *Index Medicus* will cease to exist. The death of this periodical will be an irreparable loss, as during the twenty-one years of its able editorship it has become an indispensable necessity in the field of medicine. Some steps must be taken to continue it under under new conditions. We are not in a position to say how this can be done; but as the question is a cosmopolitan one, some scheme by which the great medical institutions and societies of all countries could become guarantors ought not to be an impossibility. Could not the Royal Colleges of the United Kingdom take the initiative in the matter?

# SCRAPS

PICKED UP BY THE ASSISTANT-EDITOR.

**Clinical Records** (27).—This excellent story has been recently revived :—"A well-known Archbishop of Dublin was, towards the end of his life, at a dinner given by the Lord-Lieutenant of Ireland. In the midst of the dinner the company was startled by seeing the Archbishop rise from his seat, looking pale and agitated, and crying, 'It has come—it has come!' 'What has come, your Grace?' eagerly cried half-a-dozen voices from different parts of the table. 'What I have been expecting for some years—a stroke of paralysis,' solemnly answered the Archbishop. 'I have been pinching myself for the last ten minutes, and find my leg entirely without sensation.' 'Pardon me my dear Archbishop,' said the hostess, looking up to him with a quizzical smile, 'pardon me for contradicting you, but it is my leg you have been pinching!'"

**Medical Satire.**—A friend has kindly supplied me with the following :—

Wisdom ceases not to be wisdom when it pleases her to assume the cap and bells of Folly; hence much profit can be derived from a perusal of the recently-issued "Comic Number" of the *Münchener medicinische Wochenschrift*, if readers, to borrow an expression from Rabelais, are wise enough "rompre l'os et sugcer la substantifique moelle."

Amongst the advertisements are to be seen: "Iodosanin," a new remedy for syphilis, wherein the iodine is so firmly secured no power on earth can release it; the organism is therefore protected against it; it is guaranteed to produce no iodism, *nor any other effect*.—Girls suffering from Dramatic Neurosis are thoroughly cured at the establishment of Schmierfink [Oily-tongue], Theatrical Manager, Vienna.—"Medical Assistant wanted for Hospital;" Salary £25 per annum, with board and lodging; a deduction of £22 15s. is made for attendance; liable to dismissal at a month's notice, but Assistant is otherwise bound for two years.—"Doctors required for a Club." Salary about 10d. a day; every other Good Friday a half-holiday; responsibility small, as every prescription is duly examined by the lay Committee, and if necessary corrected. Quacks and pot-house practitioners excluded, as the expense for soap and water would be too great.—"Exoteric Food for Invalids." This needs merely to be shown to the patients; strongly recommended, on the score of economy, to Hospitals and Infirmaries.—"Artificial Assistants." These are of glass and iron, with electrical and steam motive power; the surgical ones are transparent, sterilisable, call out "Lint," "Sponge," and then use them.

There is an original article by Dr. Michael Squirt on "The Artificial Production of Unsexual Generation in Man." Struck with Tolstoi's suggestion in the *Kreutzersonate*, that the actual method of generation, so crude, so coarse, is quite unworthy of our modern refinement and culture, the writer tries a lymph prepared by him from Protozoa that propagate by self-division. He experiments, by subcutaneous injection near the shoulder-blade, upon a wealthy banker, married, childless, eagerly desirous of an heir. Two heads soon form and complete themselves; but as each now claims to be the original banker and denounces the other for a scoundrel who is seeking to get possession of immense wealth and a handsome wife not his own, the dialogue grows animated. Finally two complete men are formed, to the utter bewilderment of the ever-watchful mother-in-law. Not to be outwitted, she too resolves on sub-division, and is injected accordingly. Division into four perfect individuals ensues. These now enter the bankers' mansion arm-in-arm. At the sight of the common enemy, the bankers blench with terror and collapse in a death-like swoon.—Dr. Pantschenberger's article, "A New Method of Feeding Infants," is admirable satire. The writer starts by condemning natural milk in every form, mother's milk included; maintains that modern Chemistry can in this matter excel Nature herself; and advances elaborate arguments in support of his thesis. He accordingly opens an experimental klinik with twenty-one infants, fourteen from three weeks to two

months old, and seven from four to ten months These are fed with the doctor's artificial food exclusively. Results: Twelve out of fourteen of the former perish of inveterate stomachic affections; there are hopes three of the latter seven may survive the year. Now, the Professor's sunny optimism is by no means overclouded by these results, apparently so unfavourable; on the contrary, inasmuch as the preparation contains every element that is needful for the reparation and growth of the infantile organism, Nature is manifestly in error. "Let us but hold fast to Theory," says he, "Experience must and will give way!"—The article, "A Triumph of Modern Surgery," by Professor Swindel of Mississippi College, is aimed at the extravagant hardihood of Quixotic operators. The case is as follows: A young German, engaged for two and a half years in a paint-factory in America, falls ill. Symptoms: Several times a day the stomach, after premonitory noises—rolling, gurgling, gulping,—discharges its fluid contents. Great thirst supervenes, but the drinking of fluids only aggravated the evil. As no treatment relieves, Dr. Swindel boldly determines to excise the stomach and substitute a swine's. The operation is performed. Then in the stomach is discovered the cover of a beer jug, swallowed in student days and long forgotten. Complete success. Healing *per primam*. In the exuberance of restored health, the young man shortly afterwards climbs a lamp-post, which snaps off and flings him to the ground, the lamp descending with terrific force upon his occiput and causing compound fracture of the skull. Brought almost *in articulo mortis* into Dr. Swindel's klinik, a hasty examination reveals the skull-cavity all but empty, the brain-matter having been lost through the wound. As a desperate resort, a calf's brain is planted therein, with the happiest results. The patient recovers: every mental operation is soon normal. He quits the paint-business and turns art-critic with marked distinction. "This brilliant success," says the writer, "secures for brain-transplantation an enduring place in surgery."

New Books received:—

Alois Strampfer. *The Most Common Forms of Injury arising from Cycling—to Foot-passengers.* Leipzig. 1898.

G. Sorcier. *Acceleration of the Mental Development of New-born Infants by Inoculation with Extract from the Pituitary Gland.* Paris. 1898.

John Grudger. *The Morbid Sensibility of the English—particularly in Reference to the Naval Advancement of Other Nations.* London. 1898.

Paolo Firlefanzi. *The Voluntary Procreation of Twins.* Firenze. 1898.

Contributions in verse occupy about half the number. Of these, the best perhaps is the short epigram, "The Mistaken Examination," concerning a physician whose custom is to look for fever *per anum*.

At the sitting of the Medical Association in München, November 31, 1898, Dr. Masculine proposed certain addenda to the usual code of professional etiquette, which, legislating for men only, is now obsolete. Among them are these: The male consultant is on no account to assume airs of superiority over the Doctoress, nor presume to criticise the treatment followed. Children of a Doctor and Doctoress may choose by a bare majority which parent is to take medical charge of them. In case of illness occurring in the medical husband or wife, either may give medical aid to the other gratis. This rule extends to childbirth. But if the latter event is too often repeated, the husband's fees must be settled by mutual arrangement.

**Medical Philology** (XXX.).—The *Promptorium* has "DYDERYN' for colde. *Frigucio, rigeo*," and "DYDERYNGE, *Frigitus*." Mr. Way's note quotes "dadir" from the *Catholicon Anglicum*, and from Cotgrave "*Barboter de froid*, to chatter or didder for cold, to say an ape's Paternoster;" and adds, "Skinner gives this word as commonly used in Lincolnshire, '*a Belg.* sitteren, *præ frigore tremere*.' The Medulla renders '*frigucio*, romb for cold.' In the Avowynge of King Arther, edited by Mr. Robson, to 'dedur' has the sense of shaking, as one who is soundly beaten; and in the Towneley Mysteries, Noah's wife, hearing his relation of the approaching deluge, says,

'I dase and I dedir
For ferd of that taylle.' p. 28.

Didder, to have a quivering of the chin through cold' FORBY."

Mr. Herrtage, in his edition of the *Catholicon*, has a note on "to dadir" (the Latin equivalent of which is *Frigucio*), saying: "*Dither* is still in use in the Northern Counties with the meaning of 'to shake with cold, to tremble': see Peacock's Gloss. of Manley & Corringham, Nodal's Glossary of Lancashire, &c. *Dithers* is the Linc. name for the shaking palsy, *paralysis agitans*. The Manip. Vocab. gives 'to dadder, *trepidare*.' Cotgrave has '*Claquer les dents*. To gnash the teeth, or to chatter, or didder, like an Ape, that 's afraid of blowes. *Frisson*. A shivering, quaking, diddering, through cold or feare; a trembling or horror.' See also *Friller*, *Frissoner*, and *Grelotter*.

> Boyes, gyrles, and luskyth strong knaves,
> *Dydderyng* and *dadderyng* leaning on ten staves.'
> *The Hye way to the Spyttel Hous*, ed. Hazlitt, p. 28."

Didder and dither are fairly common in colloquial speech even now. The *New English Dictionary* quotes "ditthering, rippling hysteria," from Rudyard Kipling's *Soldiers Three*.

Mr. Herrtage, calling attention to its connection with "Dayse" (which in the *Catholicon* has the meaning "to be callde" with *frigere* as one of its Latin renderings), in his note has: "Icel. *dasdr*, faint, tired; *das*, a faint, exhaustion."

The *Catholicon* has "Calde of þ^e^ axes; *frigor*." This is interestingly illustrated by Mr. Herrtage, who says "Palsgrave gives 'Chyueryng as one dothe for colde. In an axes or otherwise, *frilleux*. Ague, axes, *fyeure*.' *Axis* or *Axes* is from Lat. *accessum*, through Fr. *accez*, and is in no way connected with A.S. *æce*. Originally meaning an approach or coming on of anything, it at an early period came to be specially applied to an approach or sudden fit of illness: thus Chaucer has, 'upon him he had an hote *accesse*.' *Black Knight*, l. 136, and Caxton, 'fyl into a sekenes of feures or *accesse*.' *Paris & Vienne*, p. 25." *The Complaint of the Black Knight* is not now considered to be Chaucer's work, but the word in this sense occurs in his undoubted *Troilus and Criseyde*:

> "A charme that was right now sent to thee,
> The whiche can thee hele of thyn accesse." II. 1314–15.
>
> "What nedeth you to tellen al the chere
> That Deiphebus unto his brother made,
> Or his accesse, or his sikly manere." II. 1541–43.

Under "Axes," which in the *Catholicon* has a reference to fevers, Mr. Herrtage has this note: "In the Paston Letters, iii. 426, we read—'I was falle seek with an *axez*.' It also occurs in *The King's Quhair*, ed. Chalmers, p. 54:

> 'But tho begun mine *axis* and torment,'

with the note—'*Axis* is still used by the country people, in Scotland, for the ague.' Skelton, Works, i. 25, speaks of

> 'Allectuary arrectyd to redres These feverous *axys*.'

'Axis, Acksys, aches, pains.' Jamieson. 'I shake of the axes. *Je tremble des fieures*.' Palsgrave. 'The dwellers of hit [Ireland] be not vexede with the *axes* excepte the scharpe axes [incolæ nulla febris specie vexantur, excepta acuta, et hoc perraro]. Trevisa, i. 333. See *Allit. Poems*, C. 325, '*þacces* of anguych,' curiously explained in the glossary as blows, from A.S. *þaccian*." The *New English Dictionary* quotes from Andrew, who, in his 1527 translation of *Brunswyke's Distyll. Waters*, recommends a certain treatment "for the dayly axces or febres." Jamieson, in the passage here quoted from him, seems to have fallen into the error of interpretation against which Mr. Herrtage warns us in the note on "Calde of þe axes" given above. Concerning the different pronunciations of "ache" as a noun and a verb, I had a long note in the *Journal* for June, 1892. This is a word which we get from the Anglo-Saxon, *æce* or *ece*, a pain or unpleasant feeling.

"To say an ape's Paternoster," which occurs in Mr. Way's note above, was a proverbial expression for chattering with cold, and probably had some reference to the noise of the beads in the Rosary at every tenth of which a Paternoster was said. In addition to the instances in Cotgrave to which Mr. Way and Mr. Herrtage refer, Halliwell, in his *Dictionary of Archaic and Provincial Words*, gives Batre, Cressiner, and Dent. Under the first of these Cotgrave has "Batre le tambour avec les dents. *To chatter, didder, say an apes Paternoster*."